



Response to

**Arizona Long Term Care System (ALTCS) Elderly &  
Physically Disabled  
(E/PD) Contract for Contractors**

**Solicitation Number: YH12-0001**

Presented to

**Arizona Health Care Cost Containment System  
(AHCCCS)**

**April 1, 2011**

# Transmittal Letter





4350 E. Cotton Center Boulevard  
Building D  
Phoenix, Arizona 85040  
Phone (602) 263-3000  
Toll Free (800) 624-3879

April 1, 2011

Ms. Jamey Schultz  
Arizona Health Care Cost Containment System  
Contracts and Purchasing Section (First Floor)  
701 East Jefferson, MD 5700  
Phoenix, AZ 85034

Re: Solicitation No. YH12-0001

Dear Ms. Schultz:

Southwest Catholic Health Network Corporation, d/b/a Mercy Care Plan (MCP), is pleased to present this proposal to continue coordinating integrated managed care services for Elderly and Physically Disabled members under the Arizona Long Term Care System (ALTCS), as specified in Request for Proposal (RFP) YH12-0001.

Our proposal meets all RFP requirements and demonstrates our commitment to assisting ALTCS in delivering the highest quality long term care by continuously improving program efficiency and effectiveness while supporting member choice. This proposal includes continuing to provide ALTCS members with member-centric services in Maricopa County while expanding our effective systems and services to serve members in the Pima, and Santa Cruz GSA.

We offer extensive networks of qualified providers, convenient member access, consistent integrated services, member-centered case management and a wide array of proven medical management tools and techniques designed to holistically approach and fulfill the diverse needs of ALTCS members, including older adults and physically disabled members. Our expertise in these areas is amplified by our long experience in serving AHCCCS programs.

### **History of Successful Service**

Mercy Care Plan and its owners have a long and successful history of service in Arizona. Established in 1985 exclusively to provide Medicaid Services to the State of Arizona through a contract with the Arizona Health Care Cost Containment System (AHCCCS), MCP is one of the first AHCCCS health plans. We have worked closely with AHCCCS for more than 26 years and currently provide services to all AHCCCS programs. To further enhance our commitment to the behavioral health needs of our members, we have partnered with the Community Partnership of Southern Arizona (CPSA). CPSA is one of the State's premier behavioral health organizations with extensive experience serving AHCCCS and the Arizona Department of Health Services (ADHS) members.

MCP has supported AHCCCS programs from the beginning and we continue to work with the State of Arizona to meet the evolving health care needs of Arizonans.

Our owners, Carondelet Health Network and Catholic Healthcare West, have been serving the health care needs of Arizonans for an even longer period of time. The Sisters of St. Joseph of Carondelet opened Arizona's first hospital, St. Mary's Hospital, in 1880. In addition to St. Mary's Hospital, Carondelet sites in Tucson today include St. Joseph's Hospital, the Cerelle Center for Mammography and Carondelet Imaging Services Central. Southern Arizona's leading health care services provider, Carondelet currently serves more than 1.3 million Arizona residents. Catholic Healthcare West (CHW) also has a history of service in Arizona. The Sisters of Mercy opened St. Joseph's Hospital and Medical Center in Phoenix in 1895 and today, CHW is the eighth largest hospital provider in the nation, employing more than 60,000 caregivers in Arizona, California, and Nevada.

Mercy Care Plan is a unique ALTCS program contractor. As the only non-governmental, not-for-profit plan with provider sponsors, our very foundation was designed specifically to fulfill the mission and meet the requirements of AHCCCS. MCP and our provider sponsors have a deeply rooted and direct presence in the major urban and rural areas of Arizona. As an Arizona organization, we have established successful collaborative relationships with all stakeholders serving AHCCCS members. Our resources are devoted to improving the health and quality of life for Arizonans through our longstanding relationship with AHCCCS and our dedication to meeting its goals.

### Seamless Transition of Members

As noted in the table below, Mercy Care Plan, through its contracted health plan manager, Schaller Anderson, LLC, (Schaller), an Aetna company, has experience in accomplishing a smooth and streamlined transition of elderly and physically disabled enrollees for ALTCS, as well as on a national level as noted in the table below.

State (Program) Year	Previous Program and Enrollees	Services Performed During Transition	Transition Period
Arizona (Arizona Long Term Care Program) 2005	Managed Long- Term Care Health Plan 4,000 at-risk Members transitioned	<ul style="list-style-type: none"> <li>• Transition Planning for frail elderly and older adults with disabilities</li> <li>• Institutional and HCBS Assessment</li> <li>• Continuity of Care including service authorization, medication maintenance and review of Member Care Plans</li> </ul>	4 months
Delaware (Delaware Medical Assistance Program)  2004	Fee-for-service 90,000 Members transitioned	<ul style="list-style-type: none"> <li>• Continuity of Care including service authorizations and medication maintenance</li> <li>• Risk Stratification, including Health Risk Questionnaire (HRQ)</li> <li>• Member PCP Selection</li> <li>• Member Assessment and Care Planning</li> <li>• Provider Network Training</li> <li>• Member Education and Outreach</li> </ul>	60 Days
Missouri (Northwest	Fee-for-service 42,000 Members	<ul style="list-style-type: none"> <li>• Continuity of Care including service authorizations and medication</li> </ul>	90 Days

State (Program) Year	Previous Program and Enrollees	Services Performed During Transition	Transition Period
Missouri (ASO) 2008	transitioned	<ul style="list-style-type: none"> <li>• maintenance</li> <li>• Risk Stratification, including</li> <li>• Health Risk Questionnaire (HRQ)</li> <li>• Member PCP Selection</li> <li>• Member Assessment and Care Planning</li> <li>• Provider Network Training</li> <li>• Member Education and Outreach</li> </ul>	
Indiana (Indiana CareSelect2) 2008	Fee-for-service 12,727 Members transitioned	<ul style="list-style-type: none"> <li>• Continuity of Care including service authorizations and medication maintenance</li> <li>• Risk Stratification, including Health Risk Questionnaire (HRQ)</li> <li>• Member PCP Selection</li> <li>• Member Assessment and Care Planning</li> <li>• Provider Network Training</li> <li>• Member Education and Outreach</li> </ul>	90 days

### Expansion Performance Guarantee

Mercy Care Plan (MCP) is proud and pleased to propose expansion of our programs of high quality and responsive care and services to the Pima and Santa Cruz GSA. We currently provide the full range of AHCCCS covered services to almost 30,000 members in Pima County. Through our Medicare Advantage Special Needs Plan we also serve 15,669 state-wide dual eligible members, with 1,800 in the Pima and Santa Cruz GSA. Our history and experience in Pima and Santa Cruz, beginning in 1984, gives MCP market insight while we actively build a comprehensive network. For instance, one of our owner hospitals – St. Mary’s Hospital – has been serving the poor and disadvantaged in Tucson since 1880 and Holy Cross Hospital has been serving Nogales since 1987. This gives MCP a unique understanding of the provider community and this GSA.

In the event we receive a contract to serve ALTCS members in the Pima and Santa Cruz GSA, MCP is proposing a *performance guarantee* as a contractual commitment of our satisfactory completion of certain activities related to our Pima and Santa Cruz GSA proposal. This *performance guarantee* will be in the form of a two part performance bond. Part one is MCP’s successful transition and timely entry into the Pima and Santa Cruz GSA measured by agreed upon transition standards. Part two will be that MCP fulfills certain agreed upon service standards in the first year. MCP will post both performance bonds, each in the amount of one million dollars (\$1,000,000) at the beginning of the readiness review phase. The terms and conditions of these performance bonds will be discussed during contract negotiations and will be based on our mutual agreement of a contract amendment between AHCCCS and ALTCS. These performance bonds are in addition to the performance bond requirements as stated in RFP YH12-0001 Section D, paragraph 46 or ACOM Chapter 300, section 306.

### Member-Centric Systems and Services

Our member-centric systems and services are designed to empower members and their families to make informed health care choices. From initial risk assessment through ongoing care, MCP provides timely, responsive quality services. We encourage members to actively participate in the design and implementation of individualized plans of care to meet their specific needs. Our

goal is to assist members in achieving the best possible health outcomes and the most independent, healthy lifestyles.

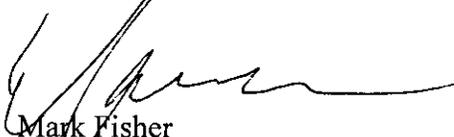
We will expand the successful patient-centered medical homes initiative launched for ALTCS members in Maricopa County, collaborating with additional provider practices in Maricopa and Pima Counties to engage and support members in maintaining good health. We will implement a number of outreach initiatives to improve the quality of care for members. We will launch a diabetes management program in collaboration with the Carondelet Medical Group in 2011 and we have agreements with PCPs in Maricopa, Pima, and Santa Cruz GSAs to make house calls to members in their homes or residential settings. We will continue to work with AHCCCS to meet ALTCS members' evolving needs.

**Contact Information**

We welcome any questions AHCCCS may have regarding our proposal, experience, capabilities or expansion plans. Please contact me at (602) 453-6027 or email: [FisherM5@Aetna.com](mailto:FisherM5@Aetna.com) to discuss our proposal further.

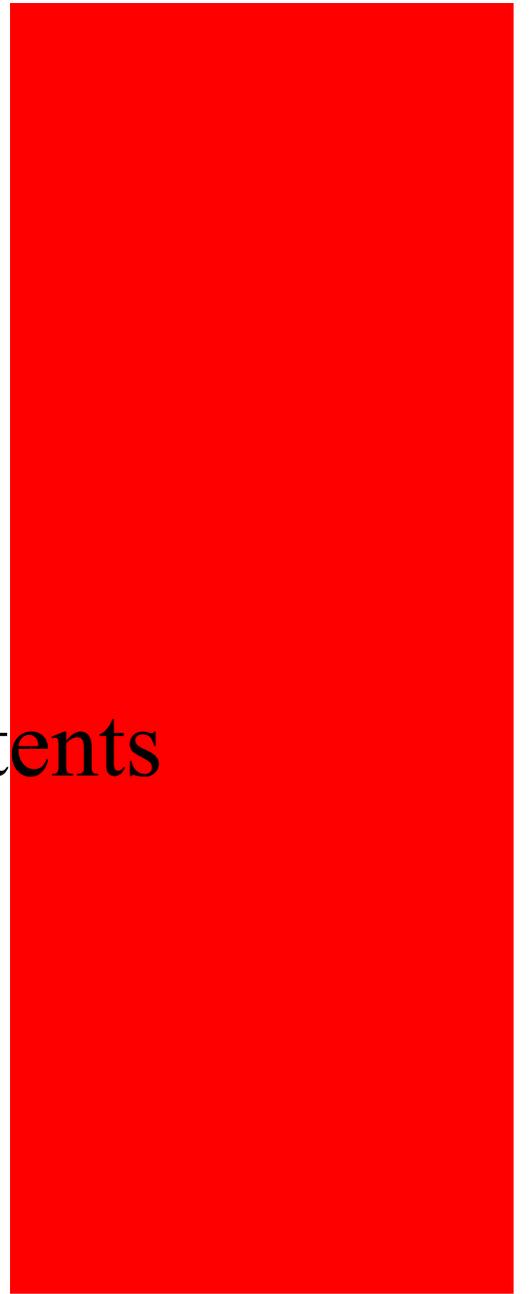
Mercy Care Plan appreciates this opportunity to present our proposal for assisting AHCCCS in serving the diverse health care needs of Arizona's Medicaid population and we look forward to continuing our commitment to meeting the goals of the ALTCS program.

Sincerely,



Mark Fisher  
President and Chief Executive Officer

# Table of Contents





## A. GENERAL MATTERS

Table of Contents	
Section	Page #
Offeror's Signature Page	2
Solicitation Amendment #1 Signature Page	5
Solicitation Amendment #2 Signature Page	6
Offeror's Checklist	7
Section G – Representations and Certifications of Offeror	10

## A. General Matters



## Offeror's Signature Page

	<b>Notice of Request for Proposal</b>		<b>AHCCCS</b>
			Arizona Health Care Cost Containment System
	SOLICITATION NO.: <b>YH12-0001</b>	PAGE 2	701 East Jefferson, MD 5700
	OF 160	Phoenix, Arizona 85034	

**OFFER**

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and best-and-final offers (if any). Signature also acknowledges receipt of all pages indicated in the Table of Contents.

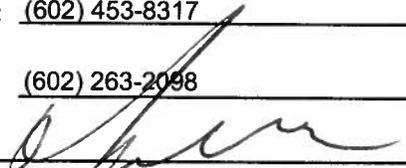
Arizona Transaction (Sales) Privilege Tax License No.:

For clarification of this offer, contact:

Name: Mark Fisher

Phone: (602) 453-8317

Fax: (602) 263-2098

  
Signature of Person Authorized to Sign Offer

MARK FISHER  
Printed Name

President and CEO

Title

Federal Employer Identification No.:

86-0527381

E-Mail Address: FisherM5@aetna.com

Southwest Catholic Health Network Corporation dba Mercy Care Plan  
Company Name

4350 E. Cotton Center Blvd., Building D

Address

Phoenix                      AZ                      85040

City

State

Zip

**CERTIFICATION**

By signature in the Offer section above, the bidder certifies:

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §§ 41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

**The bidder certifies that the above referenced organization  is/  is not a small business with less than 100 employees or has gross revenues of \$4 million or less.**

**ACCEPTANCE OF OFFER (to be completed by AHCCCS)**

Your offer, including all exhibits, amendments and best-and-final offer (if any), contained herein, is accepted.

The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. YH12-0001-

Awarded this \_\_\_\_\_ day of \_\_\_\_\_ 2011

\_\_\_\_\_  
Michael Veit, as AHCCCS Contracting Officer and not personally

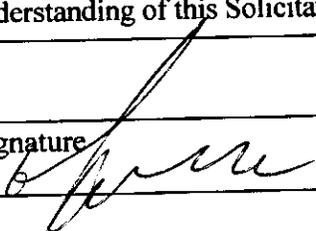
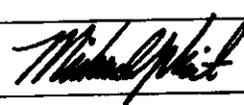


## Amendment Acknowledgements

	<b>SOLICITATION AMENDMENT</b>	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034
	Solicitation Number: <u>RFP YH12-0001</u>  Amendment Number 1 (One)  Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Contract Management Specialist: Jamey Schultz, CMS E-mail: <a href="mailto:Jamey.Schultz@azahcccs.gov">Jamey.Schultz@azahcccs.gov</a>

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

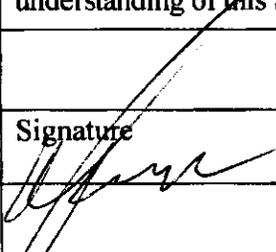
Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 24 <sup>th</sup> day of February, 2011, in Phoenix, Arizona.	
Signature		Date	
	3/28/2011		
Typed Name and Title	Mark Fisher		Michael Veit
	President & CEO		Contracts and Purchasing Administrator
Name of Company	Southwest Catholic Health Network		

Corporation, d/b/a Mercy Care Plan

	<b>SOLICITATION AMENDMENT</b>	Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034
	Solicitation Number: <u>RFP YH12-0001</u>  Amendment Number 2 (Two)  Solicitation Due Date: April 1, 2011 3:00 PM (MST)	Contract Management Specialist: Jamey Schultz, CMS E-mail: <a href="mailto:Jamey.Schultz@azahcccs.gov">Jamey.Schultz@azahcccs.gov</a>

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11 <sup>th</sup> day of March, 2011, in Phoenix, Arizona.	
Signature	Date		
	3/28/2011		
Typed Name and Title Mark Fisher		Michael Veit	
President & CEO		Contracts and Purchasing Administrator	
Name of Company Southwest Catholic Health Network Corporation, d/b/a Mercy Care Plan			



## Offeror's Checklist

**OFFEROR'S CHECKLIST**

Offerors must submit all items below, unless otherwise noted. In the column titled "Offeror's Page #," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Panel may find the Offeror's response to the specified requirement. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the proposal when reviewing a specific response to an individual submission requirement.

**A. GENERAL MATTERS**

<i>Subject</i>	<i>Reference</i>	<i>Offeror's Page #</i>
Offeror's signature page	(Front Page)	N/A
Offeror's Checklist (this attachment)	N/A	N/A
Completion of all items in Section G of the RFP	Section G	N/A

**B. CAPITATION**

<i>Subject</i>	<i>Reqmt. #</i>	<i>Offeror's Page #</i>
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	21

**C. ORGANIZATION**

<i>Subject</i>	<i>Reqmt. #</i>	<i>Offeror's Page #</i>
Moral and Religious Objection	2	39
Organization and Staffing	3	40
	4	78
	5	81
Sanctions	6	84
Claims	7	87
	8	101
	9	103
Encounters	10	106
Information Systems	11	113
	12	121
	13	124
	14	127
Grievance System	15	130
Corporate Compliance	16	137

***C. ORGANIZATION - CONTINUED***

Finance and Liability Management	17	140
	18	141
	19	142

***D. PROGRAM***

<i>Subject</i>	<i>Reqmt. #</i>	<i>Offeror's Page #</i>
Case Management	20	144
	21	147
	22	150
	23	153
	24-A	156
	24-B	159
	24-C	161
	24-D	164
Medical Management	25	166
	26	173
	27	176
	28	179
Quality Management	29	182
	30	185
	31-A	188
	31-B	191
	32	194
	33	197
	34	200
Oral Presentation	35	203

***E. PROVIDER NETWORK***

<i>Subject</i>	<i>Reqmt. #</i>	<i>Offeror's Page #</i>
Provider Network	36	205
	37	300
	38	303
	39	306
	40	309
	41	312
	42	315
	43	317
	44	320
Network Summary via EFT/SFTP	45	323



## Section G – Representations and Certifications of Offeror

## SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

*The Offeror must complete all information requested below.*

**1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED**

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

**2. CERTIFICATION OF NON-COERCION**

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

**3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING**

By signing this offer, the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and "Stark II" laws governing related-entity and compensation therefrom. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

**4. AUTHORIZED SIGNATORY**

Authorized Signatory for Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan  
[OFFEROR'S Name]

Mark Fisher President & CEO  
[INDIVIDUAL'S Name] [Title]

is the person authorized to sign this contract on behalf of Offeror.

**5. OFFEROR'S MAILING ADDRESS**

AHCCCS should address all notices relative to this offer to the attention of:

<u>Mark Fisher</u>	<u>President &amp; CEO</u>
Name	Title
<u>4350 E. Cotton Center Blvd., Building D</u>	<u>(602) 453-8317</u>
Address	Telephone Number
<u>Phoenix AZ</u>	<u>85040</u>
City	State
	ZIP

**6. OFFEROR GENERAL INFORMATION**

**a. If other than a government agency, when was your organization formed? 11/26/1985**

**b. License/Certification:** Attach a list of all licenses and certification (e.g. federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates. **NONE**

Have any licenses been denied, revoked or suspended within the past 10 years? Yes  No

If yes, please explain.

c. **Civil Rights Compliance Data:** Has any federal or state agency ever made a finding of noncompliance with any civil rights requirements with respect to your program? Yes  No  If yes, please explain.

d. **Accessibility Assurance:** Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements). Yes  No  If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.

MCP is in full compliance with Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973. We are aware that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities or be subject to discrimination. MCP is aware that other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and is in compliance with these requirements in addition to those established under ADA. Further, it is MCP's standard operating procedure that each of its facilities, provider's sites (offices, hospitals, clinics, pharmacies, emergency rooms and urgent care centers), Web sites, written materials and member service resources (Member Service and PA phone numbers) are accessible and useable by members regardless of disability. We monitor network compliance with these standards through, including but not limited to, pre-contracting site audits, subsequent site visits and quality reviews. Such standards are included in contracts as well. It is our standard operating procedure and policy that communication with members with disabilities is as effective and meaningful as communication with others.

e. **Prior Convictions:** List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.  
**None**

f. **Federal Government Suspension/Exclusion:** Has Offeror been suspended or excluded from any federal government programs for any reason? Yes  No  If yes, please explain.

g. Provide the name(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and / or reviewing published capitation rate information.

Jason Strandquist, FSA, MAAA

Name

4645 E. Cotton Center Blvd., Bldg. #1

Phoenix

AZ

Address

City

State

h. Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? Yes  No  If yes, what is the name of this firm or organization?

Name

Address

City

State

i. Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? Yes  No  If yes, is the Management Information System being obtained from a vendor? Yes  No  If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.

**Vendor:** Southwest Catholic Health Network Corporation, d/b/a Mercy Care Plan, is a not-for-profit organization jointly sponsored by Catholic Healthcare West and Carondelet Health Network. Mercy Care Plan (MCP) has worked with our contracted health plan manager, Schaller Anderson, LLC (Schaller), an Aetna company\* for the past eight years to deliver services to Arizona members. All health plan management services are subcontracted to Schaller, with oversight by MCP, through an agreement effective May 1, 2002. Included, as part of this agreement, is the provision of management information system services.

\*Schaller Anderson, LLC, is a wholly-owned subsidiary of Aetna Health Holdings, LLC, which is a wholly-owned subsidiary of Aetna Inc.

**Background with AHCCCS:** Founded in 1985, Mercy Care Plan (MCP) provides Medicaid services in the state of Arizona through a contract with the Arizona Health Care Cost Containment System (AHCCCS). MCP has a long and successful history of working with Medicare and Medicaid federally funded programs and was one of the first AHCCCS health plans, working closely with AHCCCS for more than 20 years. Over these two decades, MCP has worked with the Arizona Legislature, in cooperation with AHCCCS, to improve the quality of health services and care coordination for Medicaid enrollees and to improve the financial management of Medicaid funding. MCP provides health care services to over 330,000 Medicaid members.

**Background with Other Medicaid Programs:** Schaller, one of the nation's leading Medicaid managed care companies, has more than 20 years of experience in providing the offered services to Medicaid populations. Schaller, together with its affiliates, serves aged, disabled and special needs populations, as well as traditional populations including Temporary Assistance for Needy Families (TANF) and State Children's Health Insurance Program (SCHIP) populations. Schaller currently administers MCO benefits to over one million members in ten states (Arizona, California, Connecticut, Delaware, Illinois, Florida, Maryland, Missouri, Pennsylvania and Texas) and manages MCO benefits for over 85,000 older adults and adults with disabilities in six states (Arizona, California, Delaware, Florida, Maryland and Pennsylvania). Schaller also works with MCP to manage care for more than 15,000 dual eligibles in our MCA Special Needs Plan (SNP).

At the core of MCP's application architecture lies QNXT™, a rules based information processing system that includes 28 integrated modules. Schaller contracts with TriZetto for the use of QNXT™. QNXT™ maintains and processes the following data:

#### QNXT™

At the core of MCP's application architecture lies QNXT™, a rules-based information processing system that includes 28 integrated modules, which maintain and process the following data:

- Claims data, including payment, coordination of care and third party liability
- Demographic and enrollment data (including prior coverage)
- Provider contract data, including network and services
- Prior authorization and special needs data
- Electronic Data Interchange (EDI) and maternity care payments
- Medicaid eligibility records, quality management (QM) and utilization management (UM) via prior authorizations (PA) and concurrent reviews

QNXT™ provides a high degree of flexibility, scalability, and integration with other systems.

**7. FINANCIAL DISCLOSURE STATEMENT**

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of December 31, 2010. However, continuing Offerors who have filed the required Financial Disclosure Statement to AHCCCS within the last 12 months need not complete this section if no significant changes have occurred since the last filing.

**a. Ownership:** List the name and address of each person with an ownership or controlling interest, as defined by 42 CFR 455.101, in the entity submitting this offer:

Name	Address	Percent of Ownership or Control
N/A		

**b. Subcontractor Ownership:** List the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Address	Percent of Ownership or Control
N/A		

Names of above persons who are related to one another as spouse, parent, child or sibling:

N/A

**c. Ownership in Other Entities:** List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest:

N/A

---



---



---



---



---



---



---

**d. Long-Term Business Transactions:** List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end:

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
N/A		

**e. Criminal Offenses:** List the name of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Name	Address	Title
N/A		

**f. Creditors:** List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror's company.

Name	Address	Description of Debt	Amount of Security
N/A			

**g. Outstanding Legal Actions:**

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization? Yes  No  If yes, provide details including the dollar amount.

2. Has your organization ever gone through bankruptcy? Yes  No  If yes, provide the year.

N/A

---



---



---

**8. RELATED PARTY TRANSACTIONS**

**a. Board of Directors:** List the names and addresses of the Board of Directors of the Offeror.

<b>Name/Title</b>	<b>Address</b>
Ruth Brinkley	Carondelet Health Network, 2202 N. Forbes Blvd., Tucson, AZ 85745
Linda Hunt	St. Joseph's Hospital and Medical Center, 350 W. Thomas Rd. Phoenix, AZ 85013
Gary Conner	Saliba Salo CHW, 251 S. Lake Ave., 7th Floor, Pasadena, CA 91101-4842
Margaret Mary McBride, RSM	St. Joseph's Hospital and Medical Center, 350 W. Thomas Rd. Phoenix, AZ 85013
Scott Nordlund	Catholic Healthcare West, 2300 N. Central Ave., 10th floor Suite 1020, Phoenix, AZ 85012
Fran Roberts, RN, PhD	Catholic Healthcare West, 185 Berry St., Ste. 300, San Francisco, CA 94107-1739
Garry Maisel	Western Health Advantage, 2349 Gateway Oaks Dr., Ste. 100, Sacramento, CA 95833
JoAnn A. Webster	Ascension Health, 4600 Edmundson Rd., P.O. Box 45998, St. Louis, MO 63145-5998
John M. Wray	Catholic Healthcare West, 185 Berry St., Suite 300, San Francisco, CA 94107-1739
Rita B. Bourgeois	Healthcare Consultant, 1340 West Via Tierra, Tucson, AZ 85704
Doug Kell	Carondelet Health Network, 2202 N. Forbes Blvd., Tucson, AZ 85745
Dr. Patricia Martinez	Carondelet Health Network, 2202 N. Forbes Blvd., Tucson, AZ 85745
John Evler	Special Assistant to the Ministry, 1345 Philomena St., Austin, TX 78723
John Peters	St. Joseph's Hospital and Medical Center, 350 W. Thomas Rd. Phoenix, AZ 85013
Paula Register	Carondelet Medical Group, 2202 N. Forbes Blvd., Tucson, AZ 85745

**b. Related Party Transactions:** Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

<u>Type of Agreement</u>	<u>Services/Related Party</u>	<u>Consideration for FYE 10</u>	<u>Date of Agreement</u>	<u>Justification</u>
Plan Management Services Agreement	<p>Mercy Care Plan holds a management agreement with Schaller Anderson of Arizona, L.L.C., in which Schaller Anderson provides management services to the Health Plan. Services provided include:</p> <ul style="list-style-type: none"> <li>• Provision of plan personnel</li> <li>• Medical management, including concurrent review, case management, disease management, and quality management</li> <li>• Credentialing</li> <li>• Claims processing and adjudication</li> <li>• Network management and contracting</li> <li>• Member and provider services</li> <li>• Operations management</li> <li>• Information systems and technology</li> <li>• Financial services and reporting</li> </ul>	\$134,230,000	4/11/ 2002	<p>Administrative costs, provided within the management services agreement, are allocated based upon direct services provided to the line of business plus an allocation of indirect costs.</p> <p>Administrative services in addition to the Health Plan management service agreement costs (i.e., marketing and insurance) are allocated to lines of business based on direct methodologies whenever possible.</p> <p>Mercy Care Plan's management services agreement, including the cost allocation methodology described above was approved by AHCCCS on April 11, 2002.</p>



**ii)** List the name and address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e. formulates, determines or vetoes business policy decisions):

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No
<b>None</b>			
<hr/>			

**9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED**

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or “overhead” services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. **Offerors shall declare all anticipated offshore services in the proposal.**

**None**  

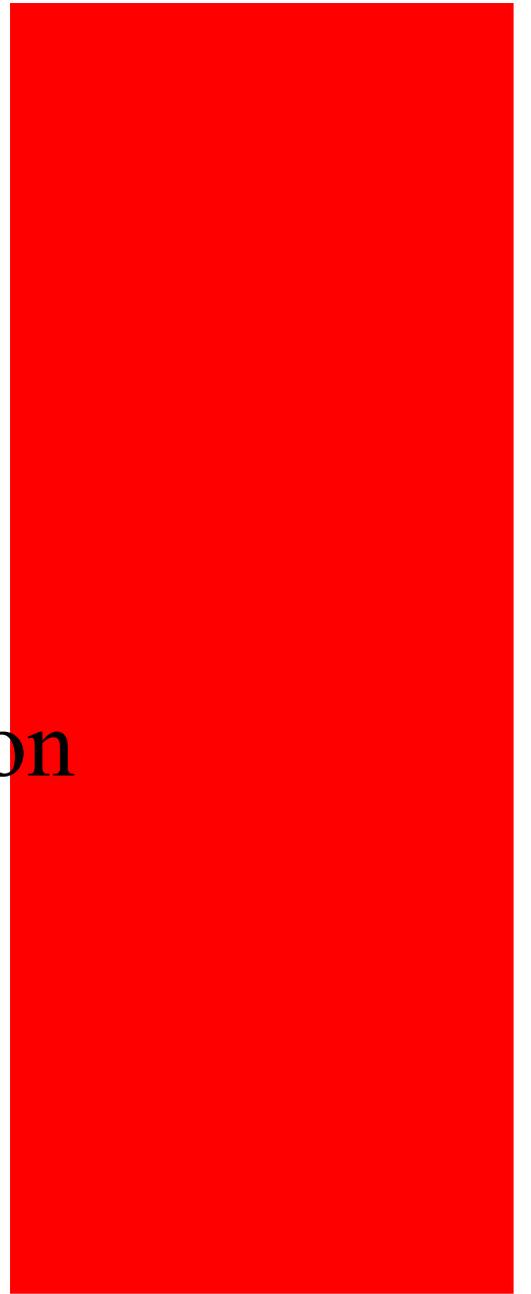
---

---

---

END OF SECTION

## B. Capitation

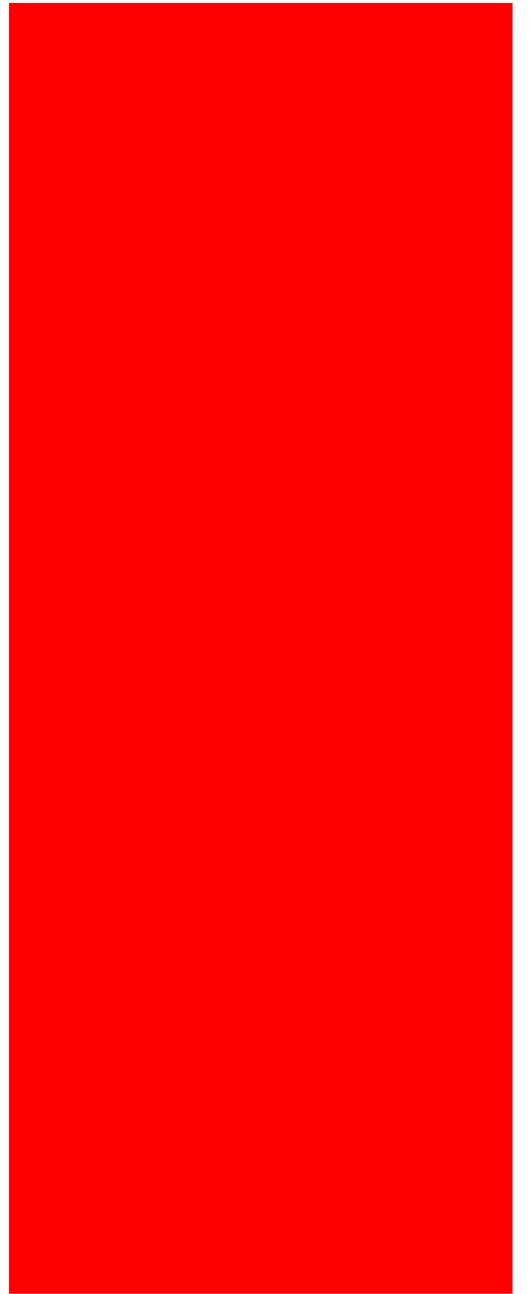




## B. CAPITATION

Table of Contents	
Section	Page #
Capitation Rate Bid	
Question 1	21

1.





**Question 1 – Capitation Rate Bid**

Southwest Catholic Health Network, d/b/a Mercy Care Plan (MCP), in response to RFP No. YH12-0001, is submitting the required capitation bid submission for Geographic Service Areas; 50 (Pima and Santa Cruz) and 52 (Maricopa). The required capitation rate bid submission for the three components; a medical component, a case management component and an administrative component can be found on the following pages.



## B. Capitation

GSA 50

# Mercy Care Plan ALTCS Oct 2011 - Sept 2012 Bid - GSA\_50

## Policy Year 30 Bid Rate Development

	Gross	Mix	Net
Nursing Facility	\$ 5,507.77	33.24%	\$ 1,830.78
Share of Cost			(265.64)
Net Nursing Facility			1,565.14
HCBS Home and Community	\$ 1,633.65	66.76%	\$ 1,090.63
Net HCBS			1,090.63
Acute Care Prior to Reinsurance			\$ 549.76
Reinsurance Offset			(195.45)
Net Acute Care			354.31
Medical Component			\$ 3,010.08
Case Management			\$113.15
Admin		2.50%	\$ 82.97
Sub-Total of Scored Components			\$ 3,206.20
Risk/Contingency @ 1%			34.02
Net Capitation			\$ 3,240.22
Premium Tax (2% of Final Cap)			66.13
Net Capitation w/ Premium Tax			\$ 3,306.35

## Mercy Care Plan ALTCS Oct 2011 - Sept 2012 Bid - GSA\_50

### ALTCS EPD Case Management Assumption Model Capitation Worksheet

<b>GSA</b>	<b>GSA_50</b>	
	Number of ALTCS EPD enrollment as of current date	4,388
	Assumed HCBS Mix %:	66.76%
<hr/>		
Assumptions:	1 Case Manager base pay:	\$49,361
	2 Case Manager supervisor base pay:	\$68,656
	3 Case Management clerical-case aides base pay:	\$42,653
	4 Employee Related Expense %	33%
	5 Case Manager/Supervisor ratio	8.7
	6 Institutional Clients/Case Mgr	120
	7 Home and Community Based Service (HCBS) clients/case mgr	48
	8 Case Management (CM) FTEs per vehicle	1
	9 Vehicle cost per mile (GSA.gov website POV mileage rates)	\$0.510
	10 Vehicle miles per day	20
	11 Vehicle days per year	156
	12 Case Aid (Secretary) / Case Manager (supervisors)	0.5
Calculations:	Case Management Clerical-case Aides FTEs required	4.2
	Case Management Clerical -case Aides FTEs rounded	4.5
	Case Management Clerical-aid Salary and ERE	\$255,278
	Case management FTEs required	73.2
	Case management FTEs required - rounded	73.2
	Case management salary and ERE	\$4,804,492
	Case management supervisor FTEs required	8.4
	Case management supervisor salary and ERE	\$768,117
	Vehicles required	81.6
	Vehicle costs	\$129,835
	Total Annual Case Management Cost	\$5,957,723
	Case Management PMPM Calculated for CYE	\$113.15

**GSA\_50 Bid Rate Development**  
***Contract Year: October 2011 – Sept 2012***

**Base Experience Period**

The base experience period includes incurred claims from October 2008 through September 2009 with runout through June 2010. Completion factors, provided by AHCCCS, were used to develop an estimate of the ultimate incurred claims and the incurred but not paid (IBNP) claim liability.

During the base experience period, the enrollment averaged 4,179 members per month. This is a reasonably credible number of members, therefore only the experience of GSA\_50's Arizona Long-Term Care System (ALTCS) eligible individuals was used in the development of the bid. GSA\_50's experience was not blended with any other data.

The incurred claims experience was segmented by rate cell and detailed claims expense category in order to apply known adjustments by rate cell or claims expense category.

**Claim Trend**

We continually analyze the change in historical medical costs for all our lines of business controlling for known changes to benefits, provider reimbursement, membership mix and risk profile. We also analyze and review published literature from consultants, federal government agencies and state government agencies.

The ALTCS line of business has shown to be very stable over the years therefore we relied predominately on the observed claim trends of MCP's experience along with expected future changes in trend to determine the trend assumptions for each claims expense category.

**GSA\_50 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

**Table I: Trend Assumptions**

<b>Claim Expense Category</b>	<b>Util per 1k</b>	<b>Unit Cost</b>	<b>PMPM</b>
Emergency	2.0%	0.3%	2.3%
Home Health	1.5%	0.3%	2.8%
Inpatient Facility	4.5%	0.3%	4.8%
Laboratory/Radiology	1.5%	0.3%	1.8%
Mental Health	9.5%	0.3%	9.8%
Misc Medical	2.0%	0.3%	2.3%
Primary Physician	2.5%	0.3%	2.8%
Outpatient Facility	2.0%	0.3%	2.3%
Specialist Physician	2.0%	0.3%	2.3%
Dental	3.5%	0.3%	3.8%
Retail Rx	1.5%	0.3%	1.8%
HCBS	2.7%	0.3%	3.0%
Nursing Facility	1.4%	0.3%	1.7%
<b>Total</b>			<b>2.4%</b>

We are using an assumption of 2.4% annual combined pmpm trend. The number of months between the base experience period and contract period, October 2011 through Sept 2012, is 36 months. Therefore the trend factor applied to the base experience period claims is 1.072 ( $1.024^{(36/12)}$ ). The trend factor is only applied to fee-for-service claims and does not apply to expenses paid to subcapitated providers. The trend applied to subcapitated providers is 0.0%.

**Claim Adjustments**

Adjustments to the base period claims are made when there is a known change that has been or will be made between the end of the base experience period and the contract period. These can take the form of changes to covered benefits, elimination of covered benefits, changes to provider reimbursement, and/or changes to the acuity of the enrolled members.

Beginning in October 2010, there were a number of changes made to covered benefits. We have estimated the impact of the changes to the Dental benefit as a 60% decrease to dental expenses. We have also estimated the impact of changes to behavioral health, podiatry, wellness and therapies as a 20% decrease to specialty physician expenses.

**GSA\_50 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

It is our understanding that beginning in April 2011, the state’s Medicaid fee schedule will be reduced for most medical services. Mercy Care Plan anticipates contracting with providers in GSA\_50 at the Medicaid fee schedule that will be current beginning in October 2011.

**Table II: Fee Schedule Change Assumptions**

<b>Claim Expense Category</b>	<b>10/2009</b>	<b>10/2010</b>	<b>04/2011</b>
Emergency	0.0%	0.0%	-5.0%
Home Health	0.0%	0.0%	-5.0%
Inpatient Facility	0.0%	0.0%	-5.0%
Laboratory/Radiology	0.0%	0.0%	-5.0%
Mental Health	0.0%	0.0%	-5.0%
Misc Medical	0.0%	0.0%	-5.0%
Primary Physician	0.0%	0.0%	-4.7%
Outpatient Facility	0.0%	0.0%	-5.0%
Specialist Physician	0.0%	0.0%	-5.0%
Dental	-5.0%	0.0%	-5.0%
Retail Rx	0.0%	0.0%	0.0%
HCBS (Home)	-5.0%	-2.5%	-2.5%
HCBS (Community)	0.0%	0.0%	0.0%
Nursing Facility	0.0%	0.0%	0.0%

**Case Management Load**

The case management load is set to \$113.15 as shown in the Case Management Assumption Model Capitation Worksheet.

**Administrative Expense Load**

The administrative expenses load is set to 2.5% of the bid rates. The resulting pmpm load is \$82.97.

**Risk/Contingency Load**

The risk/contingency load is set by AHCCCS to 1.0% of the bid rates. The resulting pmpm load is \$34.02.

**Premium Tax Load**

The premium tax load is set by AHCCCS to 2.0% of the bid rates. The resulting pmpm load is \$66.13.

**GSA\_50 Bid Rate Development**  
***Contract Year October 2011 – Sept 2012***

**Capitation Rate Change**

The bid capitation rates are fully loaded to include the case management, administrative expense, risk/contingency and premium tax loads.

The combined capitation rate pmpm is a -8.7% change from the rates currently in place for April 2011 to September 2011. The acute capitation rate is a -31.3% change from the rates currently in place for April 2011 to September 2011.

**Mercy Care Plan**  
**Arizona Long-Term Care System / Elderly and Disabled Program**  
**GSA\_50 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

**Actuarial Memorandum**

I, Jason Strandquist, am an employee of Schaller Anderson, an Aetna Company and a member of the American Academy of Actuaries. I have examined the assumptions and methods used to develop the capitation rates in the bid submission by Mercy Care Plan.

My examination included review of the actuarial assumptions and methods and of the underlying historical experience data as I considered necessary.

In my opinion, the capitation rates are developed in accordance with accepted actuarial standards consistent with Actuarial Standards of Practice Nos. 5, 23, 25, 26 and 41 and are reasonable in relationship to the benefits provided.



*March 28, 2011*

---

**Jason Strandquist, FSA, MAAA**  
Director, Actuarial Services  
Schaller Anderson, an Aetna Company  
(602) 659-1759  
StrandquistJ@aetna.com

---

Date



## B. Capitation

GSA 52

# Mercy Care Plan ALTCS Oct 2011 - Sept 2012 Bid - GSA\_52

## Policy Year 30 Bid Rate Development

	Gross	Mix	Net
Nursing Facility	\$ 5,566.80	25.82%	\$ 1,437.35
Share of Cost			(223.08)
Net Nursing Facility			1,214.27
HCBS Home and Community	\$ 1,514.50	74.18%	\$ 1,123.45
Net HCBS			1,123.45
Acute Care Prior to Reinsurance			\$ 705.16
Reinsurance Offset			(229.85)
Net Acute Care			475.31
Medical Component			\$ 2,813.03
Case Management			\$119.10
Admin		5.20%	\$ 164.42
Sub-Total of Scored Components			\$ 3,096.55
Risk/Contingency @ 1%			33.26
Net Capitation			\$ 3,129.81
Premium Tax (2% of Final Cap)			63.87
Net Capitation w/ Premium Tax			\$ 3,193.68

## Mercy Care Plan ALTCS Oct 2011 - Sept 2012 Bid - GSA\_52

### ALTCS EPD Case Management Assumption Model Capitation Worksheet

GSA

GSA\_52

Number of ALTCS EPD enrollment as of current date	8,622
Assumed HCBS Mix %:	74.18%

---

Assumptions:	1 Case Manager base pay:	\$49,361	
	2 Case Manager supervisor base pay:	\$68,656	
	3 Case Management clerical-case aides base pay:	\$42,653	
	4 Employee Related Expense %	33%	
	5 Case Manager/Supervisor ratio	8.7	
	6 Institutional Clients/Case Mgr	120	
	7 Home and Community Based Service (HCBS) clients/case mgr	48	
	8 Case Management (CM) FTEs per vehicle	1	
	9 Vehicle cost per mile (GSA.gov website POV mileage rates)	\$0.510	
	10 Vehicle miles per day	20	
	11 Vehicle days per year	156	
	12 Case Aid (Secretary) / Case Manager (supervisors)	0.5	
Calculations:	Case Management Clerical-case Aides FTEs required	8.7	
	Case Management Clerical -case Aides FTEs rounded	8.7	
	Case Management Clerical-aid Salary and ERE		\$494,896
	Case management FTEs required	151.8	
	Case management FTEs required - rounded	151.8	
	Case management salary and ERE		\$9,965,404
	Case management supervisor FTEs required	17.4	
	Case management supervisor salary and ERE		\$1,593,217
	Vehicles required	169.2	
	Vehicle costs		\$269,302
	Total Annual Case Management Cost		\$12,322,818
	Case Management PMPM Calculated for CYE		\$119.10

**GSA\_52 Bid Rate Development**  
***Contract Year: October 2011 – Sept 2012***

**Base Experience Period**

The base experience period includes incurred claims from January 2010 through December 2010 with runout through February 2011. Completion factors were used to develop an estimate of the ultimate incurred claims by month and the incurred but not paid (IBNP) claim liability.

During the base experience period, the enrollment averaged 8,453 members per month. This is a reasonably credible number of members, therefore only the experience of Mercy Care Plan's (MCP) Arizona Long-Term Care System (ALTCS) eligible individuals was used in the development of the bid. MCPs experience was not blended with the bid data available from AHCCCS.

The incurred claims experience was segmented by rate cell and detailed claims expense category in order to apply known adjustments by rate cell or claims expense category.

**Claim Trend**

We continually analyze the change in historical medical costs for all our lines of business controlling for known changes to benefits, provider reimbursement, membership mix and risk profile. We also analyze and review published literature from consultants, federal government agencies and state government agencies.

The ALTCS line of business has shown to be very stable over the years therefore we relied predominately on the observed claim trends of MCP's experience along with expected future changes in trend to determine the trend assumptions for each claims expense category.

**GSA\_52 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

**Table I: Trend Assumptions**

<b>Claim Expense Category</b>	<b>Util per 1k</b>	<b>Unit Cost</b>	<b>PMPM</b>
Emergency	1.0%	0.3%	1.3%
Home Health	2.0%	0.3%	2.3%
Inpatient Facility	3.0%	0.3%	3.3%
Laboratory	2.0%	0.3%	2.3%
Medical Pharmacy	1.0%	0.3%	1.3%
Mental Health	10.0%	0.3%	10.3%
Misc Medical	1.0%	0.3%	1.3%
Primary Physician	3.0%	0.3%	3.3%
Radiology	1.0%	0.3%	1.3%
Select Ambulatory Facility	1.0%	0.3%	1.3%
Specialist Physician	1.0%	0.3%	1.3%
Dental	4.0%	0.3%	4.3%
Retail Rx	2.0%	0.3%	2.3%
HCBS	1.3%	0.3%	1.6%
Nursing Facility	-0.3%	0.3%	0.0%
<b>Total</b>			<b>1.2%</b>

We are using an assumption of 1.2% annual combined pmpm trend. The number of months between the base experience period and contract period, October 2011 through Sept 2012, is 21 months. Therefore the trend factor applied to the base experience period claims is 1.021 (1.012 ^ (21/12)). The trend factor is only applied to fee-for-service claims and does not apply to expenses paid to subcapitated providers. The trend applied to subcapitated providers is 0.0%.

**Claim Adjustments**

Adjustments to the base period claims are made when there is a known change that has been or will be made between the end of the base experience period and the contract period. These can take the form of changes to covered benefits, elimination of covered benefits, changes to provider reimbursement, and/or changes to the acuity of the enrolled members.

Beginning in October 2010, there were a number of changes made to covered benefits. We have estimated the impact of the changes to the Dental benefit as a 60% decrease to dental expenses. We have also estimated the impact of changes to behavioral health, podiatry, wellness and therapies as a 15% decrease to specialty physician expenses.

**GSA\_52 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

It is our understanding that beginning in April 2011, the state’s Medicaid fee schedule will be reduced for most medical services. Mercy Care Plan anticipates implementing the same fee schedule change with the providers contracted to provide medical services to ALTCS members.

Mercy Care Plan has also re-contracted with a few specific providers in their network separate from the changes in the Medicaid fee schedule. Radiologists were re-contracted for a 15% reduction to the unit cost for radiology services effective October 1, 2010. Adult Foster Care, Assisted Living Homes and Assisted Living Centers were re-contracted for an average +17.6%, +1.8% and +11.4%, respectively. The Adult Foster Care and Assisted Living Homes changes were effective beginning November 1, 2010. The change in the Assisted Living Centers reimburse was effective March 1, 2011.

**Table II: Fee Schedule Change Assumptions**

<b>Claim Expense Category</b>	<b>10/2010</b>	<b>11/2010</b>	<b>04/2011</b>
Emergency	0.0%	0.0%	-5.0%
Home Health	0.0%	0.0%	-5.0%
Inpatient Facility	0.0%	0.0%	-5.0%
Laboratory	0.0%	0.0%	-5.0%
Medical Pharmacy	0.0%	0.0%	-5.0%
Mental Health	0.0%	0.0%	-5.0%
Misc Medical	0.0%	0.0%	-5.0%
Primary Physician	0.0%	0.0%	-5.0%
Radiology	-15.0%	0.0%	-5.0%
Select Ambulatory Facility	0.0%	0.0%	-5.0%
Specialist Physician	0.0%	0.0%	-5.0%
Dental	0.0%	0.0%	-5.0%
Retail Rx	0.0%	0.0%	0.0%
HCBS (Home)	-2.5%	0.0%	-2.5%
HCBS (Community)	0.0%	7.1%	0.0%
Nursing Facility	0.0%	0.0%	0.0%

**GSA\_52 Bid Rate Development**  
**Contract Year October 2011 – Sept 2012**

**Case Management Load**

The case management load is set to \$119.10 as shown in the Case Management Assumption Model Capitation Worksheet.

**Administrative Expense Load**

The administrative expenses load is set to 5.2% of the bid rates. The resulting pmpm load is \$164.42.

**Risk/Contingency Load**

The risk/contingency load is set by AHCCCS to 1.0% of the bid rates. The resulting pmpm load is \$33.26.

**Premium Tax Load**

The premium tax load is set by AHCCCS to 2.0% of the bid rates. The resulting pmpm load is \$63.87.

**Capitation Rate Change**

The bid capitation rates are fully loaded to include the case management, administrative expense, risk/contingency and premium tax loads.

The combined capitation rate pmpm is a 0.0% change from the rates currently in place for April 2011 to September 2011. The acute capitation rate is a -9.9% change from the rates currently in place for April 2011 to September 2011.

**Mercy Care Plan**  
**Arizona Long-Term Care System / Elderly and Disabled Program**  
**GSA\_52 Bid Rate Development**  
***Contract Year October 2011 – Sept 2012***

**Actuarial Memorandum**

I, Jason Strandquist, am an employee of Schaller Anderson, an Aetna Company and a member of the American Academy of Actuaries. I have examined the assumptions and methods used to develop the capitation rates in the bid submission by Mercy Care Plan.

My examination included review of the actuarial assumptions and methods and of the underlying historical experience data as I considered necessary.

In my opinion, the capitation rates are developed in accordance with accepted actuarial standards consistent with Actuarial Standards of Practice Nos. 5, 23, 25, 26 and 41 and are reasonable in relationship to the benefits provided.



*March 28, 2011*

---

**Jason Strandquist, FSA, MAAA**  
Director, Actuarial Services  
Schaller Anderson, an Aetna Company  
(602) 659-1759  
StrandquistJ@aetna.com

---

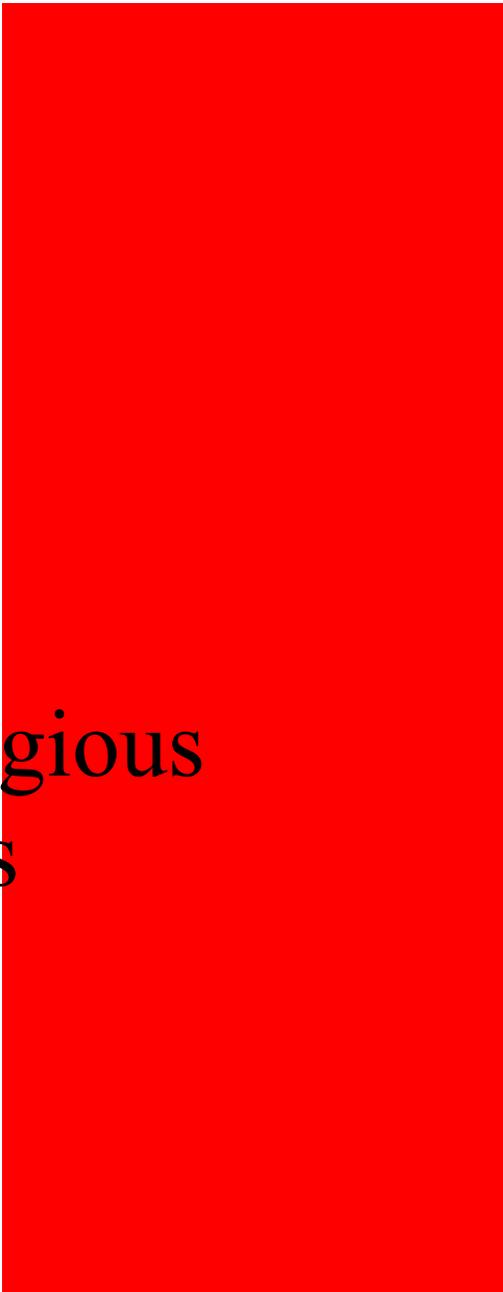
Date

## C. Organization



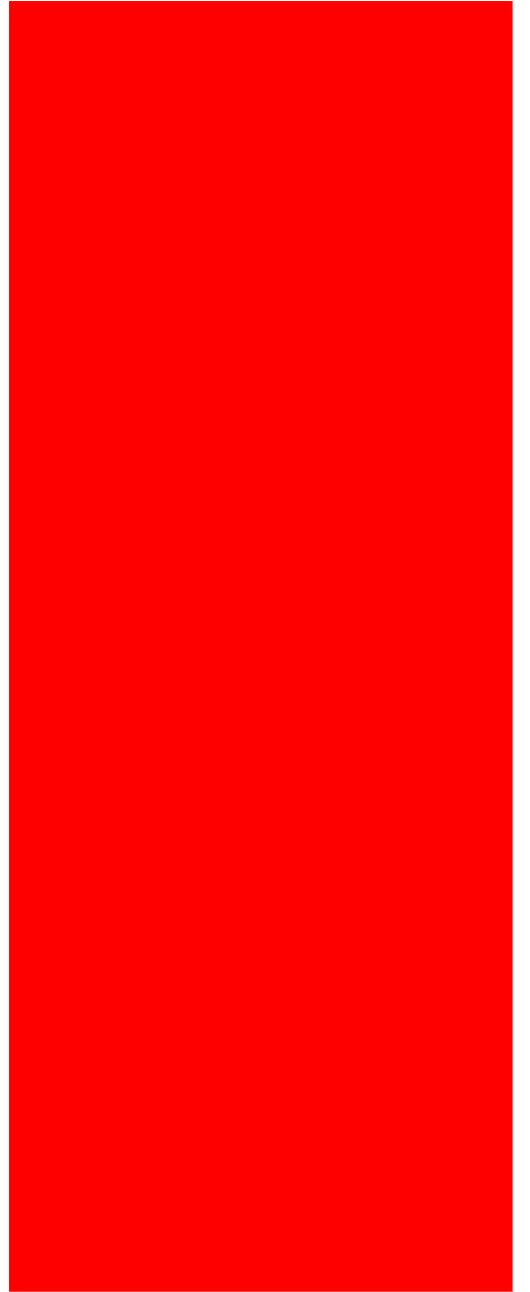
## C. Organization

Table of Contents	
Section	Page #
<b>Moral and Religious Objections</b>	
Question 2	39
<b>Organization and Staffing</b>	
Question 3	40
Question 4	78
Question 5	81
<b>Sanctions</b>	
Question 6	84
<b>Claims</b>	
Question 7	87
Question 8	101
Question 9	103
<b>Encounters</b>	
Question 10	106
<b>Information Systems</b>	
Question 11	113
Question 12	121
Question 13	124
Question 14	127
<b>Grievance System</b>	
Question 15	130
<b>Corporate Compliance</b>	
Question 16	137
<b>Finance and Liability Management</b>	
Question 17	140
Question 18	141
Question 19	142



# Moral and Religious Objections

2.





## **Question 2 – Moral and Religious Objections**

Southwest Catholic Health Network, d/b/a Mercy Care Plan (MCP) was formed as a not-for-profit organization in 1985, after representatives of the state's Medicaid agency (the Arizona Health Care Cost Containment System – AHCCCS) invited Catholic hospitals to participate in the state's Medicaid program.

MCP was jointly formed by Carondelet Health Network, a member of Ascension and St. Joseph's Hospital and Medical Center and a member of Catholic Healthcare West. The sponsors of the hospitals strongly believed that the formation of MCP was an important extension of the Catholic mission to serve the poor and persons with special needs.

Federal law mandates that state Medicaid agencies provide coverage for family planning services. Some of these services are in conflict with traditional Catholic values and MCP has religious and moral objection to providing family planning services listed in the AMPM Section 420. In the early years of Arizona's Medicaid program, AHCCCS contracted directly with providers for family planning services. However, AHCCCS discontinued this direct contracting in 1997 and moved responsibility for family planning benefits to the health plans contracted with AHCCCS to administer Medicaid benefits.

At that time, MCP presented a plan to engage a third-party administrator for family planning services to Arizona Catholic leaders and AHCCCS. A third-party administrator was engaged in April 1997, and began providing services on Oct. 1, 1997. A third-party arrangement continues today.

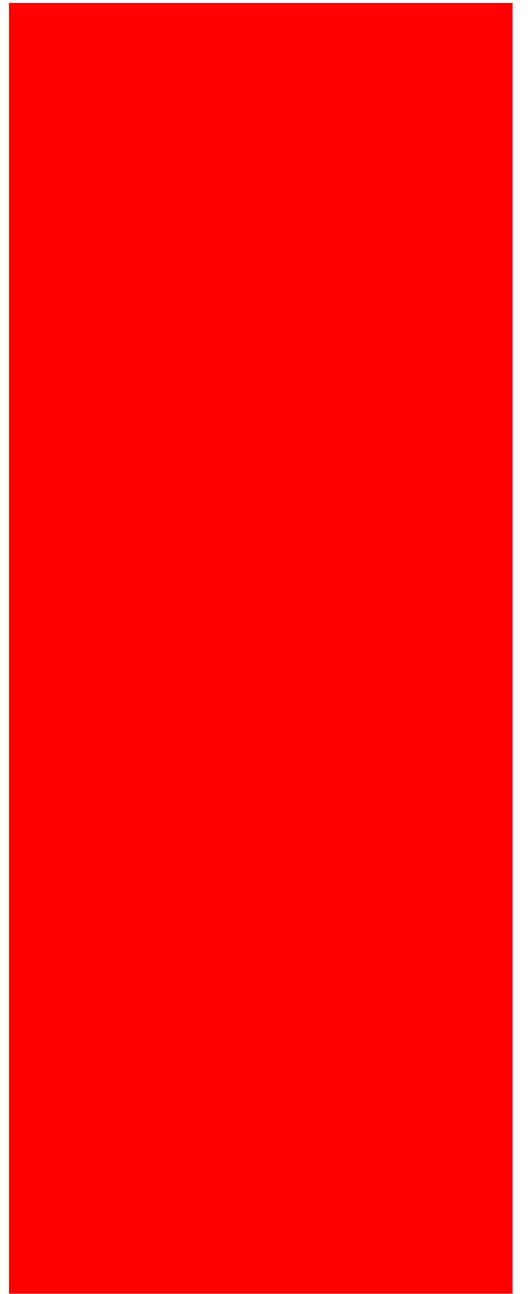
MCP holds a separate contract with Schaller Anderson, LLC (Schaller), an Aetna company to administer all family planning services that MCP objects to for religious or moral reasons. This is a continuation of an arrangement implemented in 2003 that was approved by AHCCCS. Therefore, all covered and medically necessary services will be available to AHCCCS' members by MCP or its subcontractor Schaller to meet the covered services requirement. Any payments due to Schaller for the activities defined in their contract will be the responsibility of MCP.

In accordance with A.R.S. 36-2907(A)(8) MCP's election does not disqualify MCP from delivering all other covered health and medical services and MCP elects Schaller for administrative family planning and certain OB/GYN services. Therefore, all covered and medically necessary services will be available to AHCCCS' members.

# Organization and Staffing



3.





### **Question 3 – Organization and Staffing**

Mercy Care Plan (MCP) maintains the organizational, operational, managerial, and administrative systems, fully staffed by experienced personnel, to fulfill all contract requirements. All MCP personnel responsible for day-to-day critical activities reside in Arizona and are available 24 hours-a-day, seven days-a-week. These personnel have both on-site and remote access through a secure server to all information required to identify and assist members who may be at risk, verify their current health/service status, authorize any medically necessary services (including initiating placements/services), as necessary. They are also available to perform status checks and ongoing monitoring at facilities, as required. MCP has notified AHCCCS and provided contact information for three of our key staff positions that are available 24 hours-a-day, seven days-a-week. These key staff positions are: 1) Chief Medical Officer (aka: Medical Director/CMO); 2) Vice President of Long Term Care (aka: Case Management Administrator/Manager); and 3) Vice President of Quality Management (aka: Quality Management Coordinator).

It is MCP's Policy and Procedure (P&P) that a background investigation be conducted on all candidates for MCP regular and contract employment. Employment offers are contingent upon the candidate's successful completion of a background check. The background investigation includes criminal history and part of this background investigation is to validate that individuals are not debarred, suspended, or otherwise lawfully prohibited from participating in Medicare or Medicaid in accordance with Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. An independent third party performs these mandatory background screenings. Our Human Resources Department conducts an annual examination of required government databases to confirm that any employee or contractor is eligible to participate in federal health care programs. MCP has P&Ps governing the hiring and retention of minority and disabled individuals in accordance with AHCCCS, State, and Federal requirements.

The Southwest Catholic Health Network (SCHN) Board of Directors (the Board) is our governing body and has ultimate accountability for the sufficient staffing and utilization of appropriate resources to achieve contractual compliance. The Board delegates to the Chief Executive Officer (CEO) accountability for developing and executing a staffing approach so that sufficient staff and appropriate resources are available to meet contractual compliance. Under the direction of the Board, MCP maintains a Business Continuity Plan that addresses continuity of management and administrative personnel, including but not limited to, our executive management team and critical positions (e.g., Case Managers). The CEO delegates to the Chief Operating Officer (COO) authority and responsibility for executing the staffing strategy. A major component of our staffing strategy is that we have adequate staff to achieve outcomes as required by the AHCCCS RFP YH12-0001 (hereinto referred to as RFP) and compliance with AHCCCS contractual and policy requirements. The COO, in conjunction with the Chief Financial Officer (CFO) and the CMO, perform an annual review of MCP's compliance with AHCCCS' standards, requirements, and policy.

MCP develops and maintains written P&Ps, and job descriptions for each functional area, which are reviewed, updated, and approved at least annually by the appropriate MCP manager, coordinator, director, or administrator. In addition, medical and quality management policies are reviewed, approved, and signed by our CMO. MCP revises any P&Ps that may be improved upon based on member or provider feedback. MCP's job descriptions incorporate all AHCCCS requirements for each position and are updated annually or as needed to reflect current responsibilities.

All key staff, with the exception of our Claims Administrator, who is based at a centralized claims systems location, are residents of Arizona and perform their MCP functions in the State of Arizona. Only two individuals hold more than one key staff position (one (1) employee serves as both the Contract Compliance Officer and the Compliance Officer; and another employee serves as both the Business Continuity Planning and Recovery Coordinator and the Dispute and Appeals Manager). The majority of our staff has experience working with AHCCCS programs for a number of years.

In the event of any key staff changes, MCP notifies the AHCCCS Division of Health Care Management in writing within seven days, and includes contact information for the interim personnel as part of the notification. The name and resume of the permanent key staff member is submitted to AHCCCS, together with an updated organization chart indicating key staff time allocation. MCP provides the appropriate key personnel and staff representation to attend and participate in all meetings and/or events scheduled by AHCCCS. Current resumes of all key staff, outlining their educational qualifications, career history, and current responsibilities, as required by RFP Section D, Paragraph 25, follow this response.



### ***Additional Required Staff***

In addition to the key staff identified, MCP maintains sufficient qualified staff to perform all contract duties, including: 1) Prior Authorization Staff, including Arizona-licensed nurses, who work under the direction of an Arizona-licensed registered nurse, to authorize health care 24 hours-a-day, seven days-a-week; 2) Concurrent Review Staff, including Arizona-licensed nurses, who work under the direction of an Arizona-licensed registered nurse, to conduct inpatient concurrent review; 3) Clerical and Support Staff for proper functioning of MCP's operations; 4) Provider Services Staff to enable providers to receive prompt responses and assistance; 5) Claims Processing Staff for the timely and accurate adjudication of claims; 6) Encounters Staff for the timely, accurate, and complete submission of encounter data to AHCCCS; 7) Case Management Supervisors, who have the qualifications of a Case Manager (CM) as defined in section D, paragraph 16 of the RFP, to oversee Case Management staff; 8) CMs who meet all RFP qualifications to perform assessment and care planning services for all enrolled members; and 9) Member Services staff who respond to member and provider telephone inquiries on a 24/7 basis and arrange transportation services for members, as needed.

### ***MCP Staff Training***

MCP requires that all new staff members have appropriate education and experience to fulfill their functions and thoroughly screens the background of each candidate prior to hiring. Our Learning and Performance (L&P) Department Manager has responsibility for the development, implementation, and management of our company-wide training program. L&P Department personnel dedicate 100 percent of their resources and time so that employees receive appropriate orientation, education, and training to succeed in their positions.

The L&P Department employs user friendly, comprehensive orientation, initial and ongoing training curricula to meet the different learning styles of our employees. Our curricula are developed using the Analysis, Design, Development, Implementation, and Evaluation (ADDIE) model of instructional design and are readily available within the online resource libraries located on the MCP intranet. Curricula are maintained by the L&P Department and are updated and republished biannually using interim training memorandums.

Trainings are conducted through instructor led classroom sessions, online courses and on the job training, supported by online assessments, which are evaluated daily, using a criteria checklist to determine knowledge retention and/or the need for further training. Training course attendance is captured and monitored through our learning management system and reports for all courses are available on demand.

- ***Orientation and Initial General Training:*** Orientation to MCP and initial training through our learning management system begin upon hire. This initial phase provides new employees with foundational information including, but not limited to: MCP's organization and internal operations, an overview of AHCCCS, AHCCCS' policy and procedure manuals, CMS requirements, cultural competency/health literacy, compliance and systems navigation, as well as contract, state, and federal requirements specific to individual job functions. This phase is essential to the comprehensive development of our staff in understanding their roles and responsibilities.
- ***Position Specific Training:*** Upon successful completion of initial training and prior to having contact with members, providers, or AHCCCS, employees attend specific training on the performance of their individual duties. During this phase, new employees must demonstrate knowledge, retention, and understanding of the material covered in the initial training. All personnel having contact with members or providers receive initial and ongoing training regarding the appropriate identification and handling of quality of care/service concerns.

For instance, Prior Authorization Representatives, Member Services Representatives and any employee working on potential transportation issues are trained in the geography of all GSAs where MCP holds a contract. These personnel have access to GeoAccess reports and mapping search engines for the purposes of authorizing services, recommending providers, or arranging transport for members in the most geographically appropriate location. This training phase provides employees with tools, supports, and instructions that can be applied to successful performance in their specific positions.

- ***ALTCS Training:*** Following the completion of their position specific training, employees are required to attend and participate in ALTCS specific training. During this phase, personnel must demonstrate knowledge, retention, and understanding of the material covered in the initial and position specific trainings. ALTCS specific training familiarizes our employees with the diverse needs of the ALTCS population and the roles and responsibilities of staff members, types of services provided, and challenges facing our members and providers. Staff members working with



members and providers are mentored and evaluated through on-the-job training at the outset of their service, receiving additional training as necessary.

- **Case Manager Training:** New CMs are required to complete a two month long specialized training program prior to receiving a caseload. This training program begins with two weeks of field observation visits. This is followed by three weeks of classroom training; that includes 68 hours of instruction time, 30 hours of which are spent studying MCP's P&Ps. CMs are assigned a senior case management mentor, who is available to answer questions. One hundred percent of new CMs' work is monitored by their supervisors for the first three months. In addition, CMs are required to participate in mandatory quarterly training courses and receive weekly electronic training reminders and updates regarding MCP's P&Ps. Our CMs must attend at least six critical community resource training events per year.
- **Ongoing Training:** Employees participate in ongoing training, which is mandatory for compliance, business continuity planning, quality of care issues and service concerns, cultural competencies/health literacy, reporting member/provider complaints and AHCCCS program changes resulting in regulatory updates to our training curriculum. Additional ongoing training needs are determined by trends in business operations, the tracking, and trending of issues in specific areas, feedback from managers, and new requirements/procedures/policies. Ongoing training includes, but is not limited to, instructor-led training sessions, online memo reviews, in-services, e-learning courses, and presentations. Additionally, all staff receive weekly electronic training reminders and updates regarding MCP's P&Ps.

### ***Culturally Competent/Health Literacy Services***

MCP develops, annually updates, and implements a company-wide cultural competency/health literacy plan. All employees receive initial cultural competency/health literacy training and attend, at minimum, an annual refresher course. Additional training is provided to our Member Services Representatives, Provider Services Representatives, and Medical Management personnel, and CMs to increase awareness of diverse cultural and religious practices, racial disparities in treatment and strategies for removing cultural and linguistic barriers to care. Cultural competency/health literacy information is available in our training manuals, on our website, and in ongoing employee training and education.

In addition to employee training, MCP educates providers and other stakeholders (e.g., Area Agency on Aging, Adult Protective Services, and County Public Fiduciary Office) on the importance of cultural sensitivity/health literacy to meeting members' needs. Providers receive initial and ongoing training on cultural sensitivity, health literacy, and diverse health care disparities through orientation, the provider manual, provider meetings, and in the provider section of our website. Our personnel work with providers on a daily basis to provide member-centered care that meets the needs of each member on a holistic basis and incorporates cultural competency/health literacy. MCP also produces culturally sensitive member education materials at appropriate reading levels, advising members of the tools available to assist them in navigating the health system, and informing them of their right to culturally-competent care. All materials are translated for members with Limited English Proficiency (LEP) for languages spoken by 3,000 members or 10 percent of MCP's member population, whichever is less. Vital materials are translated for LEP members when 1,000 or five percent of MCP members speak a language other than English.



## Resumes of Key Personnel



## **Mark Fisher, B.A.**

### **a. Administrator/Chief Executive Officer**

**Years of Long Term Care Experience: 9.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

### **Corporate Experience**

#### ***Administrator/Chief Executive Officer (CEO)***

##### ***Mercy Care Plan, 2009 – Present***

A highly experienced health care executive with 30 years of management experience in managed health care and managed behavioral health care for public and private sector organizations. Experienced in managing professional, clinical, technical and administrative staff and in major start-ups and project implementations.

#### **Responsibilities:**

- Establishes and maintains a system for reviewing and assessing the Arizona Health Care Cost Containment System (AHCCCS) contract, for reporting regarding the contract and for suggesting actions to improve services to the AHCCCS Administration
- Is available during working hours to fulfill the responsibilities of the administrator and to oversee the entire operation of Mercy Care Plan (MCP)
- Devotes sufficient time to ensure adherence to program requirements and timely responses to AHCCCS
- Communicates AHCCCS requirements for program implementations then leads internal resources to implement contract requirements
- Communicates ongoing implementation progress with AHCCCS representatives, the state and regulatory agencies
- Assists AHCCCS representatives, as requested, regarding issues related to all administrative services
- Achieves and maintains full understanding of the contract and its requirements; programs and policies, including service scope; special service features; history of service issues and contact with AHCCCS representatives
- Implements contract requirements
- Oversees the day-to-day operations of the staff, including chief medical officer and compliance officer
- Manages operations within the prescribed budget
- Attends multiple state-level meetings
- Maintains a macro-environmental view of the competitive landscape and the regulatory and legislative impact to Mercy Care Plan
- Develops provider relations, provider services, community involvement and promotes awareness of Mercy Care Plan
- Supports business operation with strategic planning and development of operating plans
- Works with the management team to develop quality improvement and cost savings initiatives
- Motivates and leads a high-performance management team, which includes recruiting, training, developing and retaining experienced staff

---

#### ***Chief Operating Officer***

##### ***Mercy Care Plan, 2008 – 2009***

#### **Responsibilities:**

- Overall responsibility for Mercy Care Plan operations
  - Direct responsibility for adherence to program requirements and timely responses to AHCCCS Administration
  - Led and managed all hands-on operational aspects and activities of various functional areas within the Plan
  - Assisted the chief executive officer in the successful growth and performance of the Plan
-



## **Mark Fisher, B.A.**

### **a. Administrator/Chief Executive Officer**

#### ***Senior Vice President and Chief Operating Officer***

***Fallon Community Health Plan (FCHP), Worcester, MA, 2002 – 2008***

#### **Responsibilities:**

- Led development and implementation of a strategic plan that redefined the organization's business model as a result of a major governance change from a physician run, group model HMO to an independent, diversified not-for-profit health care services organization
- Led the creation of a comprehensive commercial product development department
- Led the creation of a formalized Business Process Management function
- Led the creation and implementation of an acquisition strategy
- Completed selection of an EMR technology vendor to support FCHP's Program for All Inclusive Care for the Elderly (PACE)

---

#### ***Vice President, Operations***

***Massachusetts Behavioral Health Partnership (ValueOptions), Boston, MA, 1996 – 2002***

#### **Responsibilities:**

- Managed start-up of operations and implementation of MBHP, the organization formed to administer the Massachusetts Medicaid program behavioral health carve-out
- Planned and oversaw a re-procurement of the inpatient provider network
- Managed the implementation, enhancement and maintenance of an integrated care management and claim processing system
- Led effort and oversaw the management and implementation of key IT infrastructure enhancements
- Led statewide effort to successfully establish the Massachusetts Consumer Satisfaction Team (Massachusetts CST)

---

#### ***Director, Managed Care Operations***

***United HealthCare, Hartford, CT, 1990 – 1996***

#### **Responsibilities:**

- Was responsible for large national account and national medical managed care implementations, also coordination of clinical and administrative activities
- Led efforts in an on-going bid process on \$1.4B national account, also awarded managed care point of service business with direct responsibility for 44 network site implementations

---

### **Education**

- B.A., English, Cleveland State University, Cleveland, OH
-



## **Lorry Bottrill, B.S., C.P.A.**

### **a.1. Chief Operating Officer/Medicare Administrator**

**Years of Long Term Care Experience: 4.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

#### **Corporate Experience**

##### ***Chief Operating Officer/Medicare Administrator***

***Mercy Care Plan, 2009 – Present***

##### **Responsibilities:**

- Works with the Administrator/CEO to provide day-to-day leadership, management and oversight of Mercy Care Plan's (MCP's) operations, interfacing with corporate office staff as required
- Ensures adherence to program requirements and provides timely responses to the division administration; interfaces with corporate office staff as required
- Is available during working hours to fulfill the responsibilities of the position and to oversee the entire operation of MCP
- Responsible for driving MCP to achieve and surpass performance metrics, profitability, and business goals and objectives
- Provides timely, accurate, and complete reports on MCP's operating condition
- Develops policies and procedures for assigned areas, ensuring that other impacted areas, as appropriate, reviews new and changed policies and assists in collaborative efforts related to the development, communication and implementation of effective growth strategies and processes
- Is available, if required, to spearhead the implementation of new programs, services and preparation of bid and grant proposals
- Collaborates with the MCP management team and others to develop and implement action plans for the operational infrastructure of systems, processes, and personnel designed to accommodate the rapid growth objectives of the organization
- Assists in defining marketing and advertising strategies within state guidelines and participates in the development and implementation of marketing policies for MCP, and ensures their compliance with program regulations
- Provides assistance in preparation and review of budgets and variance reports for assigned areas
- Oversees the development of MCP's provider network, and the provider contracting function
- Acts as client-care officer through direct contact with all stakeholders
- Serves as a liaison with regulatory and other state administration agencies
- Motivates and lead a high performance management team; attracts, recruits, trains, develops, coaches, and retains staff; and fosters a success-oriented, accountable environment within MCP
- Assures compliance to and consistent application of law, rules and regulations, company policies and procedures for all assigned areas

---

##### ***Chief Financial Officer***

***Mercy Care Plan, 2008 – 2009***

##### **Responsibilities:**

- Was responsible for oversight of budget and accounting system
  - Ensured that MCP met AHCCCS' contractual financial performance
  - Was responsible for decision making on significant matters that impacted financial reporting and accounting policy matters
  - Evaluated the accounting and reporting aspects of key business strategies
-



## **Lorry Bottrill, B.S., C.P.A.**

### **a.1. Chief Operating Officer/Medicare Administrator**

#### ***Regional Finance Officer***

***Health Net of Arizona and Government Programs, 2007 – 2008***

##### **Responsibilities:**

- Was accountable for forecasting and budgeting, with over \$1 billion in revenue and 200,000 fully-insured commercial and Medicare members
- Led the finance team for the National Senior Products Division
- Managed Arizona underwriting and actuarial pricing departments

---

#### ***Vice President, Network Management***

***Ovations, United Health Group, Phoenix, AZ, 2006 – 2007***

##### **Responsibilities:**

- Was responsible for all provider operations
- Managed internal business unit contracting efforts

---

#### ***Senior Program Director, Customer Care***

***Uniprise, United Health Group, Phoenix, AZ, Jan. – Aug. 2006***

##### **Responsibilities:**

- Led member and provider call centers in three locations with over 500 FTEs
- Managed integration efforts between PacifiCare and Uniprise

---

#### ***Vice President of Operations***

***PacifiCare of Arizona, Phoenix, AZ, 2003 – 2006***

##### **Responsibilities:**

- Was accountable for over 600 employees providing claims, customer service, billing and enrollment services for the Arizona, Nevada and Colorado markets

---

#### ***Director of Strategic Development***

***PacifiCare of Arizona, Phoenix, AZ, Jan. – Oct. 2003***

##### **Responsibilities:**

- Was accountable for Preferred Provider Organization (PPO) issue resolution for Arizona Region
- Coordinated audit of Response Information Management System PPO transaction databases and led cross-functional sales meetings

---

#### ***Director of Network Management***

***PacifiCare of Arizona, Phoenix, AZ, 2000 – 2003***

##### **Responsibilities:**

- Was accountable for provider contract negotiations and managed ongoing relationships with provider partners
- Managed staff of 25 responsible for servicing over 4,000 directly contracted providers

---

### **Education**

- B.S., Accounting and Finance, University of Arizona, Tucson, AZ

---

### **Background (training, certifications, licenses, special skills)**

- Certified Public Accountant
  - Completed over 40 hours of continuing professional education per year in accounting, audit, tax, software systems, and management skills
-



**Gina M. Conflitti, M.D., F.A.C.P., C.P.E.**  
**b. Medical Director/Chief Medical Officer**

**Years of Long Term Care Experience: 7.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Medical Director/Chief Medical Officer (CMO)***

***Mercy Care Plan, 2009 – Present***

Physician executive with extensive clinical knowledge and diverse professional expertise. Adept at integrating delivery systems, implementing and improving medical management programs. Expertise includes oversight of plan medical operations, reporting directly to the CEO. Currently active Arizona-licensed physician with over 10 years of medical management experience, including experience with Medicaid populations.

**Responsibilities:**

- Administers all Mercy Care Plan (MCP) major clinical programs, as well as quality management (QM) and medical management (MM) components and activities
- Ensures timely medical decisions, including after-hours consultation, as needed
- Attends AHCCCS Medical Directors' meetings; responsible for clinical and administrative leadership for all aspects of the health plan, including program and policy development, clinical interface with regulatory agencies, legislators and the governing board
- Provides direct oversight and direction for quality committees, medical directors and nurses, as well as functions including utilization management (UM) and prior authorization, as well as the development and implementation of case management, disease management and quality improvement (QI) initiatives
- Oversees and is involved in provider recruitment activities, reviewing all providers' applications, submitting recommendations regarding credentialing/reappointment of all professional providers under MCP's scope of authority prior to the physician's contracting or contract renewal
- Oversees and is involved in provider education, in-service training and orientation
- Oversees and is involved in provider relationship development, provider profiling, clinical issue and provider issue resolution
- Oversees and directs provisional, initial and organizational credentialing and recredentialing and reviews and approves all related policies and procedures
- Responsible for continuous assessment and improvement of the quality of care provided to members (e.g., through oversight of quality of care issues, AHCCCS performance measures, Performance Improvement Projects and periodic medical studies/audits)
- Develops and implements the quality management/medical management plan and serves as the Chairperson of the Quality Management, Credentialing Committee, Medical Management and Peer Review Committees
- Oversees the Medical/Utilization Management Committee and data reporting
- Assures that adequate staff and resources are available to provide proper medical care to members and that physician staff is available to provide competent medical direction
- Oversees clinical staff, including evaluation, data analysis and the development of interventions that improve access to care, including adult preventive health, EPSDT, family planning and maternity care
- Works collaboratively with the quality management department and the Quality Improvement Committee (QIC) to identify and implement multi-departmental interventions leading to real and sustained care improvements; investigates, resolves and documents all identified quality of care concerns
- Monitors credentialing/recredentialing processes, and initiates corrective actions, as needed; directs and participates in the Fair Hearing process, which includes appeals related to adverse actions to suspend or terminate a provider's credentials



## **Gina M. Conflitti, M.D., F.A.C.P., C.P.E.**

### **b. Medical Director/Chief Medical Officer**

- Responsible for utilization data, as well as oversight of the prior authorization, concurrent and retrospective review processes
- Has overall responsibility for members' behavioral health care, including clinical oversight of behavioral health subcontractors
- Directs and oversees management of MCP's pharmacy services with the advice and participation of the Pharmacy and Therapeutics (P&T) Committee

---

#### ***Associate Chief Medical Officer***

***Mercy Care Plan, 2008 – 2009***

##### **Responsibilities:**

- Assisted in the oversight of the MCP Medical Management Program operations
- Responsible for the development, implementation and integration of medical director functions, as well as for UM, case/disease management and QM

---

#### ***Hospitalist***

***Scottsdale HealthCare Thompson Peak, Scottsdale, AZ, 2007 – 2008***

##### **Responsibilities:**

- Provided comprehensive evidence based care and was responsible for the admission through discharge of patients admitted to the hospitalist service

---

#### ***Chief Medical Officer***

***Maryvale Hospital, Phoenix, AZ, 2006 – 2007***

##### **Responsibilities:**

- Reported directly to CEO and had oversight of QM, UM and case management programs

---

#### ***Medical Director***

***HealthChoice Arizona Health Plan, Tempe, AZ, 2004 – 2006***

##### **Responsibilities:**

- Responsible for medical management and oversight of 115,000 Medicaid lives, and 4,500 Medicare Advantage/Special Needs Plan lives

---

#### ***Physician Advisor, Office of the Medical Director (part-time position)***

***Phoenix St. Luke's Medical Center, Phoenix, AZ, 2002 – 2004***

##### **Responsibilities:**

- Provided education and support of case management staff and hospitalists
- Implemented Core Measures Pilot Program and developed policies and processes for core measures including CHF, pneumonia, and acute MI

---

#### ***Medical Director, Quality Assurance***

***Phoenix St. Luke's Medical Center, Phoenix, AZ, 2001 – 2001***

##### **Responsibilities:**

- Provided education, support and oversight of case and QM departments, and physician oversight for QM and case management

---

### **Education**

- Residency, Internal Medicine, St. John Hospital & Medical Center, Detroit, MI
- M.D., Wayne State University School of Medicine, Detroit, MI
- B.A., Chemistry, Wayne State University, Detroit, MI

---

### **Background (certifications, licenses, special skills, etc.)**

- Board Certified, American Board of Internal Medicine; permanent Arizona Medical License AZ28650; DEA License, BC1554523; Fellow, American College of Physicians (ACP); Member, American College of Physician Executives (ACPE); Certified Physician Executive (CPE)



**Chuck M. Sowers, B.A.**  
**c. Chief Financial Officer**

**Years of Long Term Care Experience: 4.25**

**Years in Current Position: 1.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Chief Financial Officer***

***Mercy Care Plan, 2010 – Present***

Experienced and dynamic executive with 20 years of progressive experience primarily in the health care industry. Wide-ranging background in the areas of health plan operations, hospital management and public accounting. Areas of expertise include: financial and strategic planning, contract analysis, provider reimbursement methodology, business development and contract negotiation.

**Responsibilities:**

- Oversees the budget, accounting systems and financial reporting implemented by Mercy Care Plan (MCP)
- Ensures that MCP meets all contractual financial performance and reporting requirements set forth by the Arizona Health Care Cost Containment System (AHCCCS)
- Directs the activities of a group of managers and integrates execution of activities across these managers
- Makes decisions on significant matters that impact financial reporting and accounting policy matters, both on a Generally Accepted Accounting Principles (GAAP) and statutory basis, as well as overseeing operational aspects stemming from such issues
- Evaluates and analyzes the accounting and reporting aspects (GAAP and statutory) of key business strategies
- Oversees the implementation of effective processes to achieve business goals
- Represents the company on issues of importance by meeting with accounting and regulatory standard setters, professional groups and community organizations
- Builds effective teams across the organization and assists in ensuring appropriate staffing and development for staff succession
- Partners with the controller to execute short- and long-range strategic plans and integrate execution among various other units
- Communicates effectively in both verbal and written formats

---

***President and CEO***

***Health Net of Arizona, 2007 – 2010***

**Responsibilities:**

- Served as market leader and was accountable for all aspects of Health Net's Arizona operation with total annual revenues exceeding \$850 million
  - Oversaw 240 local associates, including 20 management team members, and served as consultative leader to corporate executive management regarding Arizona financial results, contracting trends, forecasting, strategic planning and the local regulatory environment
  - Responsibilities included oversight of personnel management, sales and marketing, product development, pricing and underwriting, community affairs, network management, compliance, medical management and financial reporting
-



## **Chuck M. Sowers, B.A. c. Chief Financial Officer**

***Chief Financial Officer  
Health Net of Arizona, 2003 – 2007***

**Responsibilities:**

- Served as market leader for the functional areas of financial planning, underwriting, actuarial services, contract analysis and financial data systems
- Drove the Arizona business unit to record financial results in fiscal year 2006
- Implemented a bottom-up forecasting process to clearly project provider trends and impact of strategic adjustments and initiatives
- Provided leadership and technical guidance for the development of experience-based employer group reporting to enhance commercial renewal process and revenue opportunities, as well as network, contracting and negotiating strategies

---

***Director of Financial Planning and Analysis – Desert Region  
PacifiCare of Arizona, 2000 – 2003***

**Responsibilities:**

- Served as regional leader for the functional areas of contract analysis, provider reporting and the forecasting and analysis of health care costs
- Served as key leader in the development of long-term network management contracting strategies and reimbursement methodologies
- Led the effort to create an automated Data-Mart system to produce all-inclusive regional profit and loss schedules

---

***Director of Reimbursement and Financial Analysis  
Chandler Regional Hospital- CHW, 1996 – 2000***

**Responsibilities:**

- Was responsible for health system contract analysis and negotiation
- Prepared and presented monthly contract analysis to the hospital's Finance Committee and Board of Directors, as well as all monthly reporting, accounting entries and analysis related to the patient financial services department
- Negotiated risk settlements and prepared non-delegated claims audits for capitated contract arrangements

---

***Senior Financial Analyst, FHP of Arizona  
FHP, Inc., 1991 – 1996***

**Responsibilities:**

- Responsible for monitoring overall evaluation of risk and medical costs, including estimation of the claims incurred but not reported for both PacifiCare risk-claims and for claims administered by PacifiCare on behalf of service providers

## **Education**

- B.A., Accounting, Arizona State University, Tempe, AZ



**Mark H. Clark, Pharm.D.**  
**d. Pharmacy Coordinator/Director**

**Years of Long Term Care Experience: 29.25**

**Years in Current Position: 9.25**

**Location: Phoenix, AZ**

**Corporate Experience**

**Pharmacy Coordinator/Director**  
**Director, Medicaid Pharmacy Benefits**  
**Schaller Anderson LLC, Phoenix, AZ, 2002 – Present**

Health care executive and Arizona licensed pharmacist with extensive background in AHCCCS administration with 23 years of experience in the areas of pharmacy and home health management.

**Responsibilities:**

- Oversees and administers prescription drug and pharmacy benefits, including management of pharmacy benefits, centralization of pharmacy prior authorizations, analysis of pharmacy utilization, oversight of pharmacy benefit manager (PBM) relationships, development of drug utilization guidelines and policies and assistance for health plans in pharmacy-related activities/programs
- Provides overall leadership, oversight, direction and performance management for the corporate pharmacy department; accountability to the MCP chief medical officer (CMO) for the support of MCP values, mission and vision; and support to the CMO in carrying out quality measure/ indicator (QM/QI) functions related to pharmacy services
- Reviews health plan census material for pharmacy utilization trends then provides data analysis for quality management and utilization management (QM/UM) to detect and documents patterns; identifies poly-pharmacy and inappropriate prescribing for members/populations then recommends quality improvement and resource management measures to reduce waste, unnecessary treatment, and margin of error
- Oversees development and submission of pharmacy prior authorization and step therapy policies, procedures and criteria to the Prior Authorization Review Panel for approval
- Ensures compliance with clients' prospective and retrospective drug utilization review (RDUR) guidelines; oversees participation in RDUR programs; participates in RDUR annual planning; and serves as main RDUR program coordinator
- Supports disease management program construction/ implementation for high-risk populations with case managers and the departments of disease management and medical management
- Maintains, reviews and revises the preferred drug list (PDL), analyzes physician drug utilization performance and provides feedback
- Monitors programs and procedures for compliance with AHCCCS, state and federal utilization, and quality and risk management regulations
- Initiates programs to identify and correct fraud and abuse, also encourages quality improvement and efficiency
- Facilitates employee and provider training/ continuing education
- Assists case managers in efforts to resolve member issues as needed
- Monitors local and national pharmacy trends, analyzes patterns to effectively manage utilization and service quality then examines policy development in managed health care, pharmaceutical management
- Works with the CMO to facilitate quarterly Pharmacy & Therapeutics Committee meetings to evaluate potential formulary additions

---

**Pharmacy Director**  
**Mercy Care Plan, Phoenix, AZ, 1994 – 2002**

**Responsibilities:**

- Managed the pharmacy benefit and pharmacy prior authorization units
-



**Mark H. Clark, Pharm.D.**  
**d. Pharmacy Coordinator/Director**

***Independent Healthcare Consultant***

***River Healthcare Services, Phoenix, AZ, March – Nov. 1994***

**Responsibilities:**

- Consulted to HMOs, infusion providers and home health agencies
- Reviewed, developed and analyzed formularies, inpatient concurrent review, review treatment regimens and prior authorization requests

---

***Center Manager***

***Roche Professional Service Center, Phoenix, AZ, 1992 – 1994***

**Responsibilities:**

- Managed all aspects of home care infusion and managed care contracting

---

***General Manager***

***Caremark Connection – AIDS Treatment Centre, Phoenix, AZ, 1990 – 1992***

**Responsibilities:**

- Developed, implemented and managed a center for HIV-positive patients to receive infusion services, nutritional counseling and supportive care

---

***Manager***

***Caremark, Phoenix, AZ, 1989 – 1990***

**Responsibilities:**

- Managed all aspects of home care infusion and managed care contracting

---

***Director***

***Physician Care/Caremark Partnership, Phoenix, AZ, 1988 – 1989***

**Responsibilities:**

- Managed all aspects of home care infusion and managed care contracting

---

**Education**

- Pharm.D., Creighton University, Omaha, NE
- B.S., Pharmacy, Creighton University, Omaha, NE
- B.A., History, Indiana University, Bloomington, IN

---

**Background (training, certifications, licenses, special skills)**

- Postdoctoral clinical residency, Albert B. Chandler Medical Center, University of Kentucky, Lexington, KY
  - AZ State Board of Pharmacy license #8698
-



**Robert K. Thielen, D.D.S., M.B.A.**  
**e. Dental Director/Coordinator**

**Years of Long Term Care Experience: 11.25**

**Years in Current Position: 11.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Dental Director/Coordinator***  
***Mercy Care Plan, 2000 – present***

Health care executive and Arizona licensed dentist with extensive background in Arizona Health Care Cost Containment System (AHCCCS) administration. Brings over 28 years of experience in the areas of dentistry, quality management and utilization review.

**Responsibilities:**

- Reviews and approves or denies dental services
- Coordinates dental activities of Mercy Care Plan (MCP) and provides required communication between MCP and the AHCCCS
- Develops standards governing the availability of acceptable dental services within MCP
- Develops policies and procedures that impact dental care, and evaluates proper utilization and quality of dental services
- Serves as MCP dental liaison between providers of care, AHCCCS Administration, and other dental agencies at county, state, and federal levels
- Supports the chief medical officer (CMO) in fulfilling quality measure/indicator (QM/QI) functions related to dental services
- Manages dental prior authorization department with direct staff reports
- Educates network dentists on dental coverage and meets to resolve any issues
- Collaborates with the CMO to promote and deliver health services to EPSDT-eligible members
- Works with the quality management preventive and wellness (P&W) unit and the CMO to identify, develop and implement effective strategies to further improve utilization of EPSDT oral health services
- Develops outreach strategies to enhance member utilization of oral health services

***Dental Consultant***  
***Wolfe Consulting Group, Phoenix, AZ , 1998 – 2006***

**Responsibilities:**

- Implemented dental division within established medical consulting group
- Provided comprehensive consulting in dental practice management, including sales, acquisitions, marketing, and new practice startups

***Independent Dental Consultant, National Provider Review Unit***  
***Aetna Insurance, Hartford, CT, 1998 – 2005***

**Responsibilities:**

- Provided on-site facility and chart audits of practices in eight western states
- Directed input and quality improvement recommendations
- Hired, trained, evaluated and managed professional staff



**Robert K. Thielen, D.D.S., M.B.A.**  
**e. Dental Director/Coordinator**

***Practitioner and Staff Dentist***

***CIGNA HealthCare of Arizona, Phoenix, AZ , 1997 – 1999***

**Responsibilities:**

- Responsible for planning, scheduling, and treating senior patients in large HMO setting
- Interacted with dental management at all levels

---

***Practitioner/Supervising Dentist/Consultant***

***Paralign Staffing Services, Phoenix, AZ, 1995 – 1997***

**Responsibilities:**

- Provided technical skills, management, and consulting services to dental practices in transition due to sale, illness, or disability of owner/dentist

---

***Private Practice***

***Scottsdale and Youngtown, AZ, 1982 – 2005***

**Responsibilities:**

- Designed and built private practice with emphasis on comprehensive, quality care and adherence to current medical and legal standards
- Maintained significant patient populations from CIGNA Dental, Blue Cross/Blue Shield, and Delta Dental

---

***Managing Dentist/Staff Instructor***

***Crestwood Career Academy, Tempe, AZ, 1982 – 1985***

**Responsibilities:**

- Provided dental services while training students in clinical dental assistant program
- Maintained financial viability of clinic through a number of capitation/PPO insurance plans

---

**Education**

- D.D.S., Loyola University School of Dentistry, Chicago, IL
- M.B.A. with emphasis in health care management, Arizona State University, Tempe, AZ
- B.A., Psychobiology, University of California, Los Angeles, Los Angeles, CA

---

**Background (training, certifications, licenses, special skills)**

- Licensed to practice dentistry in Arizona and Colorado, Western Dental Licensing Board, 1982 (holds current licenses in both states)
  - AZ license # - 2903
  - CO license # - 105273
-



**Matt Cowley, M.B.A.**  
**g. Dispute and Appeal Manager**  
**h. Business Continuity Planning and Recovery Coordinator**

**Years of Long Term Care Experience: 10.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

### **Corporate Experience**

***Business Continuity Planning and Recovery Coordinator***  
***Dispute and Appeals Manager***  
***Vice President, Medicare Products and Appeals***  
***Mercy Care Plan, 2009 – Present***

A health care executive with 15 years of experience in managed care and systems development. Extensive background in product management, planning and strategic development. Product head for Mercy Care Advantage (MCA), a Medicare/Medicaid dual-eligible special needs plan.

#### **Responsibilities:**

- Responsible for cross-functional operations and business results for the MCA business
  - Leads the development, coordination and maintenance of a comprehensive business contingency plan and validation methodology to ensure Mercy Care Plan (MCP) ability to recover in the event of an unforeseen disruption to facilities, technology systems or applications
  - Has overall responsibility for business continuity planning, focused on maintaining business continuity with business unit plans for critical business areas, functions and applications then works with business unit management to enhance contingency planning
  - Guides the development, implementation and administration of the business continuity and recovery planning policy
  - Ensures adherence to ACOM's Business Continuity and Recovery Planning Policy
  - Performs all departmental administrative activities, including staff meeting attendance, monthly status reporting, budgeting, strategic planning, expense processing, documentation and other activities in a timely manner and in accordance with Arizona Health Care Cost Containment System (AHCCCS) guidelines
  - Manages the MCP appeals department, manages and adjudicates member and provider disputes arising under the grievance system including member grievances, appeals and State Fair Hearing requests and provider claims disputes
  - Builds strong functional teams through formal training, diverse assignments, coaching, mentoring and other developmental techniques
  - Manages to performance measures and standards for quality service and cost effectiveness and coaches team/individuals to take appropriate action
  - Manages team productivity and resources, communicates productivity expectations and balances workload to achieve customer satisfaction through prompt/accurate handling of customer concerns
  - Works with the compliance officer and Compliance Committee to ensure adherence to the compliance plan, which is designed to guard against fraud and abuse
  - Ensures work of team meets AHCCCS, federal and state requirements and quality measures, with respect to letter content and turnaround time for complaints and appeals and grievance handling
-



**Matt Cowley, M.B.A.**  
**g. Dispute and Appeal Manager**  
**h. Business Continuity Planning and Recovery Coordinator**

*Vice President of Planning and Strategy*  
*Schaller Anderson Incorporated, Phoenix, AZ, 2008*

**Responsibilities:**

- Developed company-wide operating and strategic plans and reporting results as part of Aetna's management process
- Drove analytical efforts to identify and prioritize opportunities to improve operations, and better support the health plans administered by Schaller Anderson

---

*Director of Integration*  
*Schaller Anderson, Phoenix, AZ, 2007*

**Responsibilities:**

- Worked with managers across functions to plan and implement Schaller Anderson's transition to its new role as Aetna's Medicaid Business Unit

---

*Engagement Manager*  
*L.E.K. Consulting, San Francisco, CA, 2001 – 2007*

**Responsibilities:**

- Served as strategic advisor to managed health care industry clients
- Led consultant and client teams through a range of corporate advisory assignments in the commercial, Medicaid and Medicare markets, providing analytical and research services, creating and driving strategic initiatives to implementation and developing and communicating answers to clients' most critical strategic problems
- Focused on several aspects of improving clients' competitiveness, including medical cost-related issues, helping both businesses and health plans to successfully recognize and count counter trends and adopt best practices

---

*Information Technology Consultant*  
*Accenture (formerly Andersen Consulting), San Francisco, CA, 1996 – 1999*

**Responsibilities:**

- Led software product development teams of consultants and clients through design and implementation phases
- Developed systems and processes for Fortune 500 clients in the financial services industries
- Defined new product business and regulatory requirements to support new territory expansion into difficult Massachusetts car insurance market
- Conducted detailed analysis of processes and regulations
- Designed data model and user interaction for JAVA-based insurance policy issuance application

**Education**

- M.B.A., Harvard Business School, Cambridge, MA
  - B.A., English, Brigham Young University, Provo, UT
-



**Brian A. Horgeshimer, B.S.**  
**f. Compliance Officer**  
**i. Contract Compliance Officer**

**Years of Long Term Care Experience: 18.25**

**Years in Current Position: 4.25**

**Location: Phoenix, AZ**

### **Corporate Experience**

#### ***Compliance Officer / Contract Compliance Officer***

***Mercy Care Plan, 2007 – Present***

Health care executive with extensive knowledge of Arizona Health Care Cost Containment System (AHCCCS) requirements and standards, having worked with AHCCCS for 18 years (11.5 years with the Agency and 6.5 years with contracted health plans).

#### **Responsibilities:**

- Serves as the primary point-of-contact for all operational issues
- Coordinates the tracking and submission of all contract deliverables; fields and coordinates responses to all AHCCCS inquiries and coordinates the preparation and execution of contract requirements
- Provides leadership and oversight including supervision, compliance monitoring, file management, regulator communications and reporting
- Implements and oversees Mercy Care Plan's (MCP) compliance program
- Designs, maintains, administers, monitors and oversees the daily functioning of the compliance program and conducts or directs mandatory compliance training and annual refresher courses for employees
- Encourages employees, members, providers and other stakeholders to report fraud and abuse without fear of retaliation
- Investigates, directs and manages internal monitoring and auditing of the compliance program, tracking compliance issues and maintaining a compliance log that is used to monitor issue resolution
- Is available to all employees as a management official and has designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General
- Initiates corrective actions by assessing compliance issues received through any compliance mechanism (including the compliance hotline) that relate to operational functions not delegated to subcontractors
- Prepares and forwards fraud and abuse reports to regulatory and governmental agencies as required, including written notification to the AHCCCS Office of Program Integrity within 10 working days of discovery of suspected fraud and abuse
- As contract compliance officer, serves as the primary point of contact for all operational issues
- Coordinates the tracking and submission of contractual compliance deliverables and monitors tracking, investigation and reporting of contract compliance issues in accordance with regulatory and policy requirements
- Meets with any employee, member, provider or stakeholder to resolve contract compliance issues
- Fields and coordinates responses to all regulatory inquiries, as well as all electronic, telephonic and written inquiries and/or requests from the Division
- Coordinates the preparation and execution of contract requirements, including Operational and Financial Reviews (OFRs), random and periodic audits and ad hoc reports and visits
- Serves as a resource to MCP personnel, providers, members and other parties for issues, inquiries and requests including providing information regarding contract compliance
- Investigates, directs or manages internal monitoring and auditing of contract compliance



**Brian A. Horgeshimer, B.S.**  
**f. Compliance Officer**  
**i. Contract Compliance Officer**

***Director of Compliance***  
***Arizona Physicians IPA, 2005 – 2007***

**Responsibilities:**

- Responsible for the oversight of the APIPA compliance program for the Medicare and Medicaid lines of business
- Conducted Health Insurance Portability Act (HIPAA) training and education and directed HIPAA compliance audits
- Responsible for coordination and direction of CMS and AHCCCS on-site audits, reviews and subsequent corrective action plans

---

***Operations and Compliance Officer***  
***Arizona Healthcare Cost Containment System (AHCCCS), 2003 – 2005***

**Responsibilities:**

- Provided administrative oversight and compliance monitoring for two acute care health plans, as well as the Comprehensive Medical and Dental Program (CMDP) and Children's Rehabilitative Services
- Coordinated OFRs of assigned health plans and programs from initial scheduling through final report write-up
- Served as liaison to health plan staff for program compliance issues

---

***Executive Staff Assistant, Office of Managed Care***  
***Arizona Healthcare Cost Containment System (AHCCCS), 1997 – 2003***

**Responsibilities:**

- Coordinated, reviewed, and revised the Arizona Department of Health Services Behavioral Health and Arizona Long Term Care System contracts
- Assisted in the development and implementation of new programs, policies and procedures resulting from federal and state initiatives
- Provided technical assistance on complex behavioral health policy issues to contracted health plans, clients, AHCCCS and Arizona Department of Health Services personnel

---

***Administrative Services Officer II, Office of Policy Analysis and Coordination***  
***Arizona Healthcare Cost Containment System (AHCCCS), 1993 – 1997***

**Responsibilities:**

- Monitored and tracked state and federal legislation and researching and analyzing pertinent issues that impact the agency
- Represented AHCCCS executive management at the governor's office, Legislature, and external policy and advocacy meetings

---

**Education**

- B.S., Speech Communication, Northern Arizona University, Flagstaff, AZ
-



**Juman Abujbara, M.B., B.S., M.P.H.**  
**j. Quality Management Coordinator**

**Years of Long Term Care Experience: 20.25**

**Years in Current Position: 11.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Quality Management Coordinator***  
***Vice President, Quality Management***  
***Mercy Care Plan, 2000 – Present***

Health care executive with extensive background in Arizona Health Care Cost Containment System (AHCCCS) administration and a Diplomate of the American Board of Quality Assurance and Utilization Review Physicians. Has over 28 years of experience in the areas of medical management, quality management, utilization review and compliance.

**Responsibilities:**

- Has experience in Quality Management and Improvement (QM/QI) and directs the activities of the QM department staff
- Monitors and audits the health care delivery system to meet the goal of providing health care services that improve member health status and health outcomes
- Ensures individual and systemic quality of care
- Integrates quality throughout the organization and implements process improvements
- Oversees and directs the credentialing and re-credentialing processes then reviews all related policies and procedures
- Ensures a credentialed provider network, monitoring credentialing and re-credentialing processes then initiates corrective actions, as needed
- Assimilates information to proactively develop quality activities aligned with Mercy Care Plan (MCP) strategies and values
- Ensures compliance with AHCCCS, Arizona Long Term Care Services (ALTCS) and Division of Developmental Disabilities (DDD) regulations and requirements for QM/QI activities and links the QM activities to business goals
- Proactively builds strong teams and business relationships, both internally and externally
- Serves as a resource and subject matter expert on aspects of the QM program to develop and influence business strategies
- Makes QM decisions based on the results of research and data analysis and has responsibility for decision making regarding the design, development, and implementation strategy of QI projects and initiatives
- Resolves, tracks and trends quality of care grievances, ensures a credentialed provider network and manages a QM functional department including development and oversight of performance metrics and application of human resources policies and procedures
- Forms and leads cross-functional teams to assist business units in integrating quality into their strategic and operational plans
- Evaluates and prioritizes recommendations for quality improvement to senior management and/or customers
- Partners with sales and marketing across all segments in their efforts to acquire and retain customers (e.g., responding to RFPs), quality presentations, request for measurement information
- Develops and implements the infrastructure of the QM/QI program and the patient safety strategy
- Develops, implements, and evaluates the organization's policies and procedures to meet business needs
- Directs/provides enhancements to business processes, policies infrastructure to improve operational efficiency across the organization



**Juman Abujbara, M.B., B.S., M.P.H.**  
**j. Quality Management Coordinator**

- Influences department business owners and leaders to reach solutions to meet the needs of plan sponsors, regulators and other customers while meeting departmental objectives
- Performs strategic analysis of business performance data to address plan sponsor needs
- In partnership with business owners, supports design and development of new or enhanced products and services and translates knowledge of subject and business needs into clear strategic business plans
- Serves as a technical, professional and/or business expert that may cross multiple business functions

***Administrator, Office of the Medical Director***

***Arizona Healthcare Cost Containment Center (AHCCC) Administration, 1994 – 2000***

**Responsibilities:**

- Developed, implemented and managed all acute care health programs
- Negotiated and awarded contracts for independent review organizations and monitored health plans for compliance with all federal and state requirements
- Analyzed and approved all clinical studies submitted by health plans

***Manager, Maternal and Child Health Program***

***Arizona Healthcare Cost Containment Center (AHCCC) Administration, 1991 – 1994***

**Responsibilities:**

- Developed, implemented and evaluated maternal and child health programs

***Primary Care Physician***

***Amman, Jordan, 1982 – 1988***

**Responsibilities:**

- Provided primary care medical services to the underserved population

**Education**

- Medical Baccalaureate, Ain Shams University, Cairo, Egypt
- Baccalaureate in Surgery, Ain Shams University, Cairo, Egypt
- Master in Public Health, University of California, Los Angeles, Los Angeles, CA

**Background (training, certifications, licenses, special skills)**

- Diplomate of the Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Physicians



## **Faye Lockwood, M.S.**

### **k. Performance/Quality Improvement Coordinator**

**Years of Long Term Care Experience: 4.25**

**Years in Current Position: 4.25**

**Location: Phoenix, AZ**

#### **Corporate Experience**

##### ***Performance/Quality Improvement Coordinator***

##### ***Health Care Quality Management Consultant***

***Mercy Care Plan, 2007 – Present***

##### **Responsibilities:**

- Focuses organizational efforts on improving clinical quality performance measures
- Develops and implements performance improvement projects
- Utilizes data to develop intervention strategies to improve outcomes
- Reports quality improvement and performance outcomes
- Manages mailings to constituents
- Writes Structured Query Language (SQL) code for reports and mailings
- Creates and maintains applications

---

##### ***Remedy Administrator***

***COMSYS, Inc., Phoenix, AZ, 2001 – 2007***

##### **Responsibilities:**

- Designed and implemented crystal reports such as service level agreement reports, quality reports and ticket reports
- Managed remedy projects
- Documented financial and accounting processes
- Administered remedy applications
- Trained and mentored the users of the applications after creating user guides and training documents

---

##### ***Remedy Administrator***

***Leap Source, Inc., Tempe, AZ, 2000 – 2001***

##### **Responsibilities:**

- Designed and implemented crystal reports
- Documented and tracked our clients' accounting and financial issues
- Maintained and upgraded the call center application

---

##### ***Senior Operations Specialist***

##### ***Honeywell, AlliedSignal Aerospace Engines***

***Phoenix, AZ, 1998 – 2000***

##### **Responsibilities:**

- Created and implemented an Excel- and Access-based application
  - Organized and coordinated Six Sigma projects
  - Mentored Black Belt and Green Belt candidates through Six Sigma training and projects
  - Participated in rewriting the "thought process map" documentation
  - Facilitated Six Sigma Green Belt training
-



## **Faye Lockwood, M.S.**

### **k. Performance/Quality Improvement Coordinator**

#### ***Systems Engineer***

***Honeywell, AlliedSignal Aerospace Engines***

***Phoenix, AZ, 1995 – 1998***

#### **Responsibilities:**

- Manage assigned projects
- Gather and display metrics by querying the data warehouse using SQL
- Administer the data warehouse the data warehouse in a UNIX environment using Oracle

#### **Education**

- M.S., Applied Statistics, W.P. Carey School of Business, Arizona State University, Tempe, AZ
- B.S., Information Systems, W.P. Carey School of Business, Arizona State University, Tempe, AZ
- A.A., Project Management, ESI International, Arlington, VA
- Six Sigma Black Belt Certification, Honeywell

#### **Background (certifications, licenses, special skills, etc.)**

- Silver Award Winner, Aetna
- Accomplishment Award, COMSYS
- Performance Award, LeapSource Incorporated
- Six Sigma Tool Methodology presentation, Society Of Women Engineers
- Toastmaster presentations, AlliedSignal
- "Going For the Gold" and Operational Excellence Awards, AlliedSignal
- Alpha Iota Delta, National Honor Society of the Decision Sciences Institute, ASU
- Quantitative Business Analysis, Faculty Award, ASU
- Dean's List (1989 and 1990)
- Management Leadership Training, AlliedSignal



**Daniel P. Jansen, M.S.A., M.S.W., C.P.H.Q.**  
**I. Maternal Health/EPSTD Coordinator**

**Years of Long Term Care Experience: 7.25**

**Years in Current Position: 7.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Maternal Health/ EPSTD Coordinator***

***Director, Quality Management***

***Mercy Care Plan, 2004 – Present***

Experienced health care professional with over 20 years of progressive experience in quality management. Possesses a Master's degree in both administration and social work and is a Certified Professional in Healthcare Quality.

**Responsibilities:**

- Oversees prevention and wellness unit whose primary focus is delivery of Early Periodic Screening, Diagnosis and Treatment and Maternal and Child Health (EPSTD/MCH) services, including member family planning
- Develops, implements and evaluates the Mercy Care Plan (MCP) quality management program to ensure:
  - Member receipt of maternal care, postpartum care and EPSTD services
  - Member awareness of family planning services and preventive health strategies
  - Identification of member needs and provision of coordination assistance
  - Interface with community partners
- Directs EPSTD/MCH processes such as:
  - Outreach to members and providers regarding EPSTD/MCH, including health promotion
  - Monitoring of EPSTD/MCH performance measures
  - Review and improvement of EPSTD and pediatrics forms, processes and protocols
  - Provision of prenatal care and family planning services
- Oversees preparation of monitoring and data trend reports that are reviewed by Quality Improvement Committee and Quality Management/ Utilization Management Committee
- Participates in Quality Improvement Committee meetings
- Supervises a staff of quality management outreach specialists and quality consultants to meet quality and performance measure goals

---

***Quality Manager, Bureau of Quality Management & Evaluation***

***Division of Behavioral Health Services***

***Arizona Department of Health Services, 2000 – 2004***

**Responsibilities:**

- Supervised a staff of quality analysts
- Managed the successful implementation of a quality management system for the Tribal Regional Behavioral Health Authorities

---

***Manager, Membership Accounting***

***PacifiCare of Arizona, 1998 – 2000***

**Responsibilities:**

- Supervised three supervisors and oversaw the work of 20 staff members
  - Significantly improved the reconciliation process for Health Care Financing Administration accounts
  - Acted as the key management representative for successful implementation of the Balanced Budget Act
-



**Daniel P. Jansen, M.S.A., M.S.W., C.P.H.Q.**  
**I. Maternal Health/EPSTD Coordinator**

***Manager, Administration***

***Insurers Administrative Comp., Phoenix, AZ, 1996 – 1998***

**Responsibilities:**

- Supervised two supervisors, a trainer and oversaw the work of 30 customer service representatives
- Managed the successful implementation of a HIPAA compliance program, affecting the member enrollment and claims adjudication process

***Manager, Quality Review***

***Employers Health Insurance, Green Bay, WI, 1987 – 1995***

**Responsibilities:**

- Supervised two supervisors and oversaw the work of 12 quality analysts
- Managed a department of research analysts
- Successfully implemented an external customer feedback process and internal key indicators
- Identified key service variables affecting retention and overall customer satisfaction

***Director, Adolescent Treatment Program***

***Brown County Mental Health Center, Green Bay, WI, 1982 – 1987***

**Responsibilities:**

- Directed a dynamic outpatient treatment program for adolescents and their families as an alternative to inpatient psychiatric care
- Significantly expanded the program to serve a larger number of clients within the community

**Education**

- M.S.A., Administration, University of Wisconsin, Green Bay, WI
- M.S.W., Social Work, University of Wisconsin, Madison, WI
- B.S., Social Work, University of Wisconsin, Oshkosh, WI

**Background (training, certifications, licenses, special skills)**

- Certified Professional in Healthcare Quality (CPHQ): CPHQ ID# 13353



**Deidre Woods-Walton, R.N., M.S.N., J.D.**  
**m. Medical Management Coordinator**

**Years of Long Term Care Experience: 22.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Medical Management Coordinator***  
***Vice President, Utilization Management***  
***Mercy Care Plan, 2009 – Present***

Arizona-licensed registered nurse and experienced clinical health care professional with over 20 years of experience in medical management and Medicaid/Medicare regulatory compliance.

**Responsibilities:**

- Makes medical necessity determinations with the education and experience of an Arizona-licensed registered nurse
- Manages all required Medicaid medical management activities under Arizona Health Care Cost Containment System (AHCCCS) policies, rules and contract
- Leads medical management activities to promote quality of care for members, including the development and implementation of programs and policies
- Coordinates, manages and directs the daily activities of the medical management department, including care coordination, utilization review, concurrent review, authorizations, discharge planning, case management, disease management and medical claims review
- Ensures adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria as well as appropriate concurrent review and inpatient discharge planning
- Develops, implements and monitors the provision of care coordination, disease management and case management functions
- Monitors, analyzes and implements appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services
- Monitors prior authorization functions and assures that decisions are consistently made based on clinical criteria and meet timeliness standards
- Oversees the efficiency and effectiveness of Mercy Care Plan's medical management activities by directing daily activities and operation of the quality department and the accreditation department, including quality oversight, and Healthcare Effectiveness Data and Information Set reporting and National Committee for Quality Assurance metrics
- Serves as liaison with regulatory and accrediting agencies and other Medicaid business units

---

***Director, Concurrent Review***  
***Mercy Care Plan, 2008 - 2009***

**Responsibilities:**

- Managed the concurrent review department and was responsible for the implementation of department policies and procedures, which includes developing new policies and the revision of policies

---

***Care Management Nurse Supervisor***  
***Aetna, Inc., Thousand Oaks, CA, 2004 – 2008***

**Responsibilities:**

- Provided oversight for the implementation of Aetna medical management services and was responsible for management of medical services staff and implementation of medical management services policies and procedures
-



## **Deidre Woods-Walton, R.N., M.S.N., J.D.**

### **m. Medical Management Coordinator**

#### ***Case Management Nurse Consultant***

***Aetna, Inc., Woodland Hills, CA, 2004 – 2004***

#### **Responsibilities:**

- Developed and implemented care plans, applying case management concepts to complex issues and problem solving techniques to promote optimum patient outcomes
- Conducted comprehensive clinical assessments of member care needs

#### ***Supervisor, Appeals and Grievances***

***Kaiser Permanente, Pasadena, CA, 1999 – 2002***

#### **Responsibilities:**

- Supervised the day-to-day activities of the appeals and grievance staff
- Assisted in preparation and presentation of cases for the regional appeals committee, administrative law judge hearings, state hearings and small claims court

#### ***Medicare Regulatory Compliance Nurse Consultant***

***Kaiser Permanente, Pasadena, CA, 1996 – 1999***

#### **Responsibilities:**

- Responsible for auditing, investigating, training and education and enforcement
- Provided consultation on compliance issues impacting the organization
- Interpreted regulatory materials

#### ***Medicare Contract Administrator***

***Kaiser Permanente, Pasadena, CA, 1994 – 1996***

#### **Responsibilities:**

- Responsible for compliance with all state and federal Medicare and Medi-Cal regulations
- Identified and analyzed significant laws and regulations and impact on the plan's operations then identified, recommended and monitored company actions for compliance

### **Education**

- M.S., Nursing, University of Phoenix, Phoenix, AZ
- J.D., West Los Angeles School of Law, Los Angeles, CA
- B.S., Nursing, California State University, Los Angeles, CA
- A.A., Nursing, Los Angeles City College, Los Angeles, CA

### **Background (training, certifications, licenses, special skills)**

- Arizona Board of Registered Nursing- RN 162230
- California Board of Registered Nursing- RN 235352
- California Board of Registered Nursing Public Health Certificate
- Critical Care Certification- Kaiser Foundation Hospital
- U.S. Army Critical Care Additional Skill Identifier



**Margaret J. Little, M.S.W, L.C.S.W.**  
**n. Behavioral Health Coordinator**

**Years of Long Term Care Experience: 11.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Long Term Care Behavioral Health Coordinator***  
***Mercy Care Plan, 2009 – Present***

Licensed clinical social worker with over 25 years of experience in social work and counseling. Has extensive knowledge of Arizona Health Care Cost Containment System (AHCCCS) behavioral health services standards for the long term care population. Possesses expertise in performing utilization review and coordination of care, as well provider network development and contracting. Has excellent verbal and written skills.

**Responsibilities:**

- Devotes sufficient time to assure that the Behavioral Health Program is implemented per AHCCCS requirements
- Is responsible for ensuring Mercy Care Plan (MCP) remains in compliance with AHCCCS standards for the provision of member behavioral health services for members
- Coordinates member behavioral care needs with behavioral health providers, participates in the identification of best practices for behavioral health in a primary care setting and coordinates behavioral care with medically necessary services
- Develops processes to coordinate behavioral health care between primary care providers (PCPs) and behavioral health providers to provide and track timely referrals for outpatient services and acts as consultant for case managers regarding member behavioral health needs
- Trains staff and contract providers on access to covered behavioral health services for members
- Completes utilization review for higher level of care outpatient services and is responsible for ensuring timely transition of members from the Regional Behavioral Health Authority (RBHA) to MCP Arizona Long Term Care System (ALTCS) when member is enrolled with ALTCS
- Develops and implements behavioral health policies and procedures
- Serves as a clinical liaison for contracted providers, as well as the RBHA
- Works to identify and maintain behavioral health network

---

***Clinical Case Management***

***Schaller Anderson, Inc., Phoenix, AZ, 2005 – 2009***

**Responsibilities:**

- Provided case management services which included pre-admission, concurrent, discharge and/or retro review, follow-up assessment or outreach by phone
  - Monitored clinical care services provided to members related to mental health and substance abuse treatment to optimize clinical outcomes
  - Provided telephone triage, crisis intervention and emergency authorizations as assigned, as well as information to members and providers regarding mental health and substance abuse benefits, community treatment resources, mental health managed care programs, and behavioral health policies, procedures and criteria
  - Interacted with physician advisors to discuss clinical/authorization questions and concerns regarding specific cases
  - Participated in QI activities including data collection, tracking, and analysis
-



**Margaret J. Little, M.S.W, L.C.S.W.  
n. Behavioral Health Coordinator**

***Clinical Case Management Coordinator***

***First Health Group Corp/Coventry Healthcare, Scottsdale, AZ, 2001 – 2005***

**Responsibilities:**

- Performed clinical assessments to evaluate the medical necessity for mental health and substance abuse services for self insured benefit plans
- Consulted with company psychiatric and psychological Medical Directors
- Maintained familiarity with numerous benefit plans to assist providers and members with managing often complex benefits
- Worked with account management to obtain plan exceptions on behalf of members
- Resolves mental health claims and billing issues
- Negotiated rates for out of network facilities providing acute and sub-acute levels of care and document company savings
- Developed guidelines for mental health certification criteria

---

***Clinical Services Coordinator***

***Catalina Behavioral Health Services, Mesa, AZ, 2000 – 2001***

**Responsibilities:**

- Completed inpatient utilization management functions in the contracted psychiatric hospital
- Assessed patients for appropriate levels of care
- Performed discharge planning
- Coordinated physician visits, consults and ancillary services

---

***Medical Social Worker***

***Casa Blanca Medical Group, Mesa, AZ, 1995 – 2000***

**Responsibilities:**

- Coordinated and implemented a depression and anxiety disease management program for a large primary care setting

---

**Education**

- M.S.W., Social Work, Arizona State University, Tempe, AZ
- B.S.W., Social Work, University of Northern Iowa, Cedar Rapids, IA

---

**Background (training, certifications, licenses, special skills)**

- Certified Independent Social Worker, Arizona Board of Behavioral Health Examiners, LCSW-3553
-



## **Jennifer Sommers**

### **o. Provider Services Manager**

**Years of Long Term Care Experience: 14.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

### **Corporate Experience**

#### ***Provider Services Manager/ Representative Mercy Care Plan, 2009 – Present***

A highly experienced health care manager with over 20 years of provider relations and billing management experience in managed care. Experience spans individual physician practices, hospitals, medical groups and health plans.

#### **Responsibilities:**

- Responsible for provider services staff located throughout Arizona
- Coordinates communications between Mercy Care Plan (MCP) and subcontractors
- Implements organizational restructure: hires personnel for new job descriptions and functional responsibilities, develops regulatory desktop procedures
- Manages sufficient provider services staff to enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in Arizona Health Care Cost Containment System (AHCCCS) programs
- Maintains a sufficient provider network
- Manages performance improvement plans for underperforming staff
- Coordinates Joint Operating Committee meetings for hospital networks and ancillary providers
- Collaborates across departments to develop and implement new desktop procedures for addressing issues
- Facilitates quarterly meetings with Mercy Care long term care and Arizona Long Term Care System (ALTCS) provider networks
- Monitors and reports all provider complaints as mandated for compliance
- Develops and monitors a tracking system for appointment availability and accessibility audits
- Participates in all regulatory audits and reviews
- Coordinates the annual AHCCCS Network Plan
- Facilitates meetings with industry professional associations

---

#### ***Provider Management Transformation Independent Consultant – HTMS, Mercy Care Plan, 2008 – 2009***

#### **Responsibilities:**

- Developed and implemented action plans to address health plan deficiencies within the provider network department
- Established training tools and protocols for provider network staff and materials for Joint Operating Committee meetings
- Oversaw of day-to-day activities for assigned account executive staff

---

#### ***Quality Assurance Director/Branch Manager Acclivity Healthcare, Scottsdale, AZ, 2007 – 2008***

#### **Responsibilities:**

- Managed sales and service staff in Scottsdale branch
  - Oversaw all testing and evaluations of candidate qualifications and established guidelines for confirming candidate competencies
-



## **Jennifer Sommers**

### **o. Provider Services Manager**

#### ***Regional Billing Director***

***InSight Health Corp., Phoenix, AZ, 2005 – 2007***

#### **Responsibilities:**

- Managed billing services provided at 58 centers throughout the Southwest and California
- Developed and implemented a new policy and procedure manual

---

#### ***Revenue Services Director/Billing Manager***

***Sonora Quest Laboratories, LLC, Tempe, AZ, 2000 – 2005***

#### **Responsibilities:**

- Managed billing and revenue services for Arizona's largest clinical lab
- Managed supervisory staff, including hiring, training and counseling

---

#### ***Provider Relations Manager***

***Intergroup of Arizona, Phoenix, AZ, 1996 – 2000***

#### **Responsibilities:**

- Managed provider relations staff located throughout Arizona

---

#### ***Provider Relations Supervisor***

***Intergroup of Arizona, Tucson, AZ, 1995 – 1996***

#### **Responsibilities:**

- Supervised staff in Southern Arizona

---

#### ***Provider Relations Representative***

***Intergroup of Arizona, Tucson, AZ, 1993 – 1995***

#### **Responsibilities:**

- Educated providers on contract and regulation compliance

---

#### ***Benefits Analyst***

***Intergroup of Arizona, Tucson, AZ, 1992 – 1993***

#### **Responsibilities:**

- Led company-wide training on the system's capabilities

---

#### ***Provider Relations Assistant/Claims Processor***

***American Health Insurance – St. Francis Medical Group, Tucson, AZ, 1990 – 1992***

#### **Responsibilities:**

- Maintained database of all physician certifications and licensures

### **Education**

- Attended Pima Community College, Tucson, AZ

### **Background (certifications, licenses, special skills, etc.)**

- Member, Health Care Financial Management Association (HFMA)
- Six Sigma Green Belt



**Perry Orange, B.S.**  
**p. Claims Administrator**

**Years of Long Term Care Experience: 1.25**

**Years in Current Position: 1.25**

**Location: New Albany, OH**

**Corporate Experience**

***Claims/Encounters Administrator***  
***Vice President, Claims Administration***  
***Schaller Anderson, LLC, New Albany, OH, 2010 – present***

Experienced professional with over 15 years of experience in the health care industry, including claims administration, provider and customer service.

**Responsibilities:**

- Develops, implements and administers comprehensive claims processing systems
- Primary functions include: development and implementation of claims processing systems capable of paying claims in accordance with state and federal requirements; development of cost avoidance processes; minimization of claims recoupments; expedient claims processing timelines; and compliance with Arizona Health Care Cost Containment System (AHCCCS) encounter reporting requirements
- Responsible for claims, call center and other operations related to Aetna Medicaid business in Phoenix, Arizona
- Coordinates business policies, procedures and strategy in support of financial, operational and service requirements
- Oversees training for claims processing, inquiries, disputes, advanced research, provider requirements and satisfaction, customer service, grievance processes and call center

---

***Provider Service Center Region Head***  
***Aetna, New Albany, OH, 2008 – 2010***

**Responsibilities:**

- Led the north, central and southeast regions of the provider call center organization
- Managed and oversaw health care related call centers in New Albany, Ohio; High Point, North Carolina and Jacksonville, Florida

---

***Provider Service Center Site Lead***  
***Aetna, New Albany, OH, 2002 – 2008***

**Responsibilities:**

- Led a provider call center that was responsible for delivering best-in-class customer service to physicians, hospitals and other health care providers in the Midwest
- Coordinated business policies and procedures in support of financial, operational and service requirements

---

***Manager, Medical Claims and Customer Service***  
***Aetna, Jacksonville, FL, 2000 – 2002***

**Responsibilities:**

- Oversaw the development, implementation, and on-going execution of the strategic and operational business plan for both HMO and traditional claim and customer service areas
  - Coordinated business policies and procedures in support of financial, operational and service requirements
-



**Perry Orange, B.S.**  
**p. Claims Administrator**

*Manager, Dental Claims and Customer Service*  
*Aetna, New Albany, OH, 1996 – 2000*

**Responsibilities:**

- Oversaw the development, implementation, and on-going execution of the strategic and operational business plan for both HMO and traditional claim customer service areas
- Coordinated business policies and procedures in support of financial, operational and service requirements

**Education**

- B.S., Business Administration, Rider University, Lawrenceville, NJ

**Background (training, certifications, licenses, special skills)**

- Designation: Chartered Property and Casualty Underwriter



**Lynn E. Kruk, C.P.C.**  
**q. Provider Claims Educator**

**Years of Long Term Care Experience: 5.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Provider Claims Educator***

***Mercy Care Plan, 2009 – Present***

Health care professional with 30 years of experience in the areas of claims and provider services management.

**Responsibilities:**

- Fully integrates provider claims education with the Mercy Care Plan (MCP) grievance, claims processing, and provider relations systems
- Facilitates the exchange of information between providers and the MCP claims processing, grievance and provider relations systems
- Educates and trains providers on Arizona Health Care Cost Containment System (AHCCCS) participation and updates the provider manual to ensure compliance with AHCCCS, Health Care Group of Arizona (HCGA) and the NCQA
- Educates contracted and non-contracted providers regarding requirements for submitting timely and appropriate claims, coding updates, electronic claims transactions and electronic fund transfers through the provider manual, newsletters, training programs and office visits for writing
- Educates all providers concerning MCP resources including provider manuals, website, fee schedules and other educational avenues
- Communicates frequently and effectively with providers and obtains feedback on provider awareness about claims submission practices
- Works with the MCP call center to compile, analyze, and disseminate provider call information to appropriate MCP departments for prompt resolution of provider issues
- Identifies trends then guides strategy development to improve provider satisfaction
- Expedites business operations and assists in organizational audits as liaison with other department directors, managers and administration
- Develops in-service talking points for internal staff to for ongoing provider training and issue resolution
- Develops desktops, policies, procedures and internal documents for the provider relations department
- Prepares settlement documents and assists in monitoring the settlement process
- Works cross-departmentally with provider relations, member services and claims injury/claims research (CICR) to provide health plan updates and assist with training needs
- Oversees the MCP member grievance processes in provider services to educate providers, as well as improvements to the provider education process as providers submit issues for resolution
- Assists with coding analysis, claims and encounter issues, etc., as needed

---

***Provider Services Manager***

***Mercy Care Plan/Schaller Anderson of Arizona, 2007 – 2008***

**Responsibilities:**

- Directed the provider relations department for AHCCCS acute care
  - Evaluated and developed provider network and educated and trained providers on participation in the AHCCCS program
-



**Lynn E. Kruk, C.P.C.**  
**q. Provider Claims Educator**

***Claims Research and Adjustment Manager, Claims Schaller Anderson of Arizona, 2006 – 2007***

**Responsibilities:**

- Managed skilled nursing facility and ALTCS aspects of MCP
- Managed Mercy Care Advantage claims processing
- Developed claims department databases to improve workflows

***Claims Manager, Claims PacifiCare, Phoenix, AZ, 2000 – 2005***

**Responsibilities:**

- Directed the decentralization of accounting, underwriting and enrollment and managed adjustments of claims, recoveries and analysis of claims detail
- Oversaw claims audit team to ensure audits met corporate standards

***Claims Director Nexus, Phoenix, AZ, 1998 - 1999***

**Responsibilities:**

- Supervised all aspects of the claims department

***Claims Manager FPA Management of Arizona, Inc., Phoenix, AZ, 1995 – 1998***

**Responsibilities:**

- Supervised all aspects of the claims department

***Claims Supervisor MetLife, Rolling Meadows, IL, 1981 – 1995***

**Responsibilities:**

- Supervised a team of 43 claim approvers

**Education**

- Attended Glendale Community College, Glendale, AZ
- Attended Harper Community College, Palatine, IL

**Background (certifications, licenses, special skills, etc.)**

- Certified Professional Coder (C.P.C.)
- Member, Health Insurance Association of America (HIAA)



**Chad Dean Corbett, M.P.A.**  
**r. Case Management Administrator/Manager**

**Years of Long Term Care Experience: 19.25**

**Years in Current Position: 2.25**

**Location: Phoenix, AZ**

**Corporate Experience**

***Case Management Administrator/Manager***

***Vice President of Long Term Care***

***Mercy Care Plan, 2009 – Present***

Over 22 years experience, including 11 years of management and supervisory experience in social services, care management, and education with excellent counseling skills. Ability to communicate with people of diverse ages, backgrounds and skill levels. Experience in planning and program design. Possesses all of the qualifications of a case manager required by Arizona Long Term Care System (ALTCS).

**Responsibilities:**

- Oversees case management functions, has the qualifications of a case manager, and fulfills all case manager responsibilities, coordinating care across all facets of the delivery system
- Authorizes appropriate services and/or refers members to appropriate services and provides members with flexible and creative service delivery options, assisting them to identify their health and independent living goals
- Fosters a member-centered approach to case management and respects maximum member and family self-determination while promoting the values of dignity, independence, individuality, privacy and choice; advocates for the member/family/significant other as the need arises
- Involves the member and member's family in strengths and needs identification and in decision making, respecting their preferences, interests, needs, culture, language and belief system
- Obtains member, family and significant other input into the development and implementation of the care plan
- Utilizes a holistic approach in member assessment, taking both ALTCS covered services and other needed community resources into consideration in care planning; provides a continuum of service options and facilitates access to non-ALTCS services available throughout the community
- Educates and informs members/families about all care and service options available through the ALTCS program and advises them on how to report issues so they can be resolved in a timely manner
- Develops, implements, oversees and evaluates Mercy Care Plan long term care programs
- Provides information to providers about changes in members' functioning to assist the provider in planning, delivering and monitoring services

***Case Management Manager***

***Mercy Care Plan, 2006 – 2009***

**Responsibilities:**

- Managed case management services staff including the organization and development of high performing teams

***Case Management Supervisor***

***Mercy Care Plan, 2004 – 2006***

**Responsibilities:**

- Implemented day-to-day case management services, including recruiting, hiring, and training new case managers



**Chad Dean Corbett, M.P.A.  
r. Case Management Administrator/Manager**

***Case Management Manager  
Maricopa Long Term Care Plan, 2000 – 2004***

**Responsibilities:**

- Trained, mentored, supervised and evaluated 18 case managers

***Program Coordinator/ Trainer  
Maricopa Long Term Care Plan, 1998 – 2000***

**Responsibilities:**

- Led the ALTCS alternative residential programs

***Case Manager II  
Maricopa Long Term Care Plan, 1995 – 1998***

**Responsibilities:**

- Was responsible for: admissions assessment, service planning, reassessments, maintaining records for compliance, reporting statistical information

***Case Manager II  
Yavapai County Long Term Care, Prescott, AZ, 1993 – 1995***

**Responsibilities:**

- Performed admission assessments, developed service plans and maintained records for compliance

***Executive Director  
Meeting the Challenge – Home for Boys, Prescott, AZ, 1990 - 1993***

**Responsibilities:**

- Administered all aspects of the educational program and developed yearly budget and supervised lined staff

***Case Manager II  
Yavapai Big Brothers/ Big Sisters, Prescott, AZ, 1989 – 1990***

**Responsibilities:**

- Recruited, trained, and placed volunteers in appropriate community settings

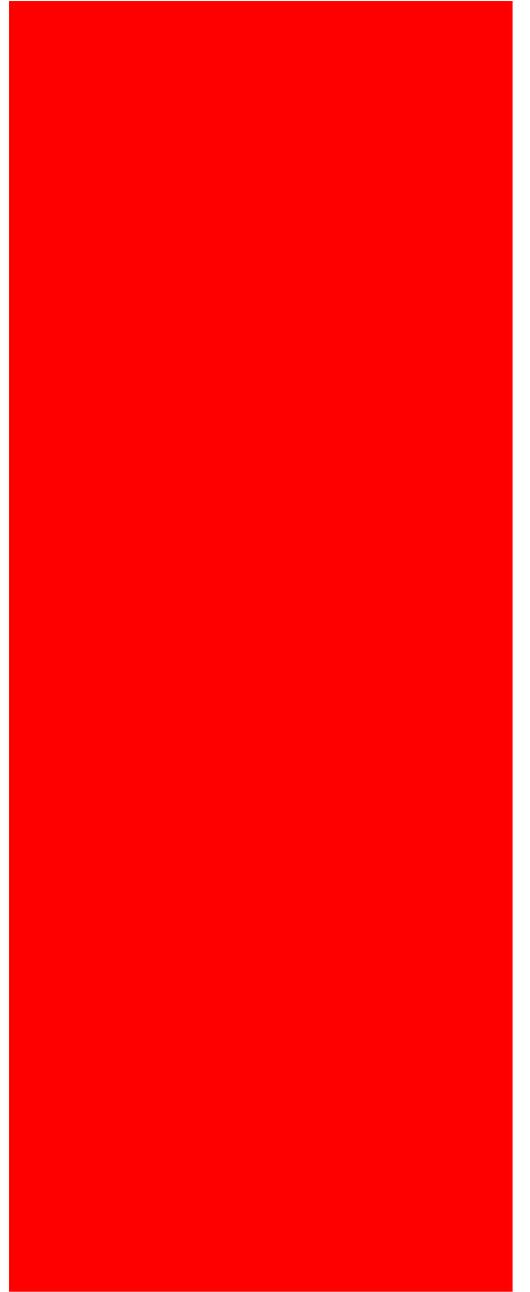
**Education**

- M.P.A., Public Administration, Western International University, Phoenix, AZ
- B.A., Psychology, University of Arizona, Tucson AZ

**Background (certifications, licenses, special skills, etc.)**

- Member, Public Policy Committee of the Alzheimer's Association

4.





#### Question 4 – Organization and Staffing

All Mercy Care Plan (MCP) key staff are full-time employees of Schaller Anderson, LLC (Schaller), an Aetna company, our health plan administrator. All key personnel required to serve the current ALTCS program are currently fulfilling the required functions of each position. Our highly qualified personnel have extensive experience in performing required services for all AHCCCS programs.

The majority of our key personnel are exclusively devoted to administering AHCCCS programs and Mercy Care Advantage [MCA, a CMS special needs plan (SNP)]. MCP product lines include: 1) ALTCS, 2) Acute Care, 3) Mercy Healthcare Group, 4) ADES/DDD, and 5) MCA. Additionally, to improve quality and accessibility of care for our dually eligible ALTCS, acute care, and members enrolled in the DD program, key personnel serving ALTCS may also serve other AHCCCS programs during periods when their services are not required on a full-time basis for ALTCS.

**a. Administrator/CEO, Mark Fisher, B.A.:** is responsible for overseeing all MCP administration and operations. He dedicates 10 percent of his time to ALTCS and 90 percent to the other MCP product lines. Mr. Fisher is supported by three executives [Chief Operating Officer (COO), Chief Financial Officer (CFO), and Chief Medical Officer (CMO)] with oversight and management control of the ALTCS program who report directly to him. Each of these staff members has extensive experience, program credibility and acceptance in the community. Mr. Fisher's other duties include compliance with all ALTCS/AHCCCS program requirements and the overall operational and financial performance of MCP.

**a.1. Chief Operating Officer, Lorry Bottrill, B.S., C.P.A.:** works with the Administrator/CEO, providing day-to-day leadership, management and oversight of MCP operations. She dedicates 20 percent of her time to ALTCS and 80 percent to the other MCP product lines. Ms. Bottrill is supported by 691 FTEs, including a Member Services Manager, Provider Services Manager, Claims Administrator, Case Management Administrator/Manager, Management Information Systems Manager, Dispute and Appeal Manager/Business Continuity Planning Coordinator and Health Plan Operations Vice President.

**b. Chief Medical Officer/Medical Director, Gina Conflitti M.D., F.A.C.P., C.P.E.:** is responsible for medical policy and operations for all MCP product lines and is actively involved in all major clinical, quality management, and medical management components of MCP. She dedicates 20 percent of her time to ALTCS and 80 percent to other MCP product lines. Dr. Conflitti is supported by a Medical Management Director, a Quality Management Director, an ALTCS Medical Director, and six additional Medical Directors, including physicians who are assigned to each of the major hospitals to administer concurrent review activities. Dr. Conflitti's other duties include the overall direction of medical management, utilization management, quality management, prior authorization, concurrent review, case management, disease management and retrospective review for MCP.

**c. Chief Financial Officer, Chuck Sowers, B.A.:** is responsible for the oversight of MCP's budget, accounting systems and financial reporting. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. He is supported by a finance director who is knowledgeable in all AHCCCS programs and by a full accounting staff located on site. His staff members have a complementary financial skill set, including financial statement accounting and regulatory reporting and reinsurance, which allow for maximum efficiency and accuracy in plan accounting and reporting. Mr. Sowers' other duties include the overall direction of the following financial activities for MCP: accounting, medical economics, budgeting, strategic planning support, reinsurance, regulatory interface, treasury functions, and long-term financial strategy.

**d. Pharmacy Coordinator/Director, Mark Clark, Pharm.D.:** is responsible for the administration and oversight of MCP prescription drug and pharmacy benefits. He dedicates five percent of his time to ALTCS; 45 percent to MCP's other programs and 50 percent to Schaller Medicaid business. His duties are centered on preferred drug list management, Drug Utilization Review (DUR), and step therapy functions for all Medicaid related programs. As pharmacy benefit director, he works closely with Express Scripts, Inc. (MCP's PBM) in pharmacy management. Mr. Clark also works in cooperation with Express Scripts to manage and direct the pharmacy network for all of MCP's Medicaid related programs. Other MCP duties include the overall direction of pharmacy prior authorization, pharmacy utilization, PBM relationship, and oversight of the pharmacy benefit for all contracted plans. He is supported by a staff of 31 FTEs, including eight (8) Clinical Pharmacists and a Prior Authorization Manager.

**e. Dental Director/Coordinator, Robert Thielen, D.D.S, M.B.A.:** is responsible for the coordination of MCP dental activities and providing required communication between MCP and AHCCCS. He dedicates five percent of his time to ALTCS and 95 percent to the other MCP product lines. He is supported by six (6) FTEs in his administration and



oversight of dental activities, including prior authorization, provider education, evaluation of proper utilization and quality of dental services, and the development of Policies and Procedures (P&Ps) that impact dental care.

**f. Compliance Officer, Brian Horgeshimer, B.S.:** is responsible for the implementation and oversight of MCP's compliance program. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. Mr. Horgeshimer's management skills are applied across all of MCP's lines of business to allow for consistency in management for each Medicaid program, and to identify patterns of fraud and abuse. He is available to all employees and has the designated and recognized authority to access records and make independent referrals to AHCCCS, Office of the Inspector General. He is supported by a compliance manager in compliance program administration, which includes: 1) supervision, 2) regulator communications, 3) compliance monitoring, 4) detection, investigation, and reporting of fraud and abuse, 5) file and record management.

**g. Dispute and Appeal Manager, Matt Cowley, M.B.A.:** is responsible for the management and adjudication of member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. Mr. Cowley identifies systemic issues for all Medicaid programs and utilizes the Appeals Database to track cases to monitor compliance with AHCCCS requirements. His other MCP duties include management of the appeals process, quality and compliance review of appeals files and appeals staff supervision. He is supported by an experienced staff of grievance and appeals specialists, including an appeals attorney, supervisor of complaint and appeals, complaint and appeals analysts, and three (3) paralegals.

**h. Business Continuity Planning and Recovery Coordinator, Matt Cowley, M.B.A.:** is responsible for the development, implementation, and administration of MCP's comprehensive business continuity plan and validation methodology in compliance with ACOM's business continuity and recovery planning policy. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. He is responsible for continuity across all MCP product lines. Mr. Cowley is supported by a core group of leaders consisting of eight (8) critical process owners that support him in his business continuity planning and recovery activities.

**i. Contract Compliance Officer, Brian Horgeshimer, B.S.:** serves as the primary point-of-contact for all MCP operational issues related to AHCCCS contracts. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. He is responsible for the coordination, tracking, and submission of all contract deliverables; fielding and coordinating responses to AHCCCS inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits, and ad hoc visits. He is supported by a Compliance Manager.

**j. Quality Management Coordinator, Juman Abujbara, M.B., B.S., M.P.H.:** is responsible for individual and systemic quality of care; integrating quality throughout the organization; implementing process improvements; resolving, tracking and trending quality of care grievances; and confirming a credentialed network. She dedicates 30 percent of her time to ALTCS and 70 percent to the other MCP product lines. Ms. Abujbara supervises medical policy and quality oversight for all MCP product lines and has direct oversight for quality management initiatives and programs designed to improve the quality of member care. Supporting her in these roles are a Director of Prevention and Wellness (aka: Maternal Health/EPSTD Coordinator), a Credentialing Manager and a Quality Management Manager.

**k. Performance/Quality Improvement Coordinator, Faye Lockwood, M.S.:** is responsible for focusing organizational efforts on improving clinical quality performance measures; developing and implementing performance improvement projects; utilizing data to develop intervention strategies to improve outcomes; and reporting quality improvement/performance outcomes. She dedicates 10 percent of her time to ALTCS and 90 percent to the other MCP product lines. Ms. Lockwood develops and implements quality improvement projects across all MCP product lines.

**l. Maternal Health/EPSTD Coordinator, Dan Jansen, M.S.A., M.S.W., C.P.H.Q.:** has oversight for EPSTD services, maternal and postpartum care and family planning services, as well as promoting preventive health strategies. The Maternal Health/EPSTD Coordinator is also responsible for identifying and coordinating assistance for identified member needs and interfacing with community partners. He dedicates 20 percent of his time to ALTCS and 80 percent to the other MCP product lines. He manages MCH/EPSTD processes and quality improvements across all product lines, including member and provider outreach, monitoring performance measures and oversight of data trend reports. He is supported by supervisory staff and quality consultants.

**m. Medical Management Coordinator, Deidre Woods-Walton, R.N., M.S.N., J.D.:** is responsible for managing all required Medicaid medical management requirements under AHCCCS policies, rules and contracts. She dedicates 20



percent of her time to ALTCS and 80 percent to the other MCP product lines. Her medical management activities promote consistency across all product lines, including: 1) adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria, 2) appropriate concurrent review and discharge planning for inpatient stays, 3) development, implementation and monitoring of care coordination, disease management and case management functions, 4) monitoring, analyzing and implementing appropriate interventions based on utilization data (while identifying and correcting over- or underutilization of services), and 5) monitoring prior authorization functions to maintain consistent decisions based on clinical criteria and adherence to timeliness standards. She is supported by one (1) RN manager and several RN supervisory support.

**n. Behavioral Health Coordinator, Margaret Little, M.S.W., L.C.S.W.:** is responsible for providing MCP personnel and providers guidance and support to address members' behavioral health needs. Ms. Little is responsible for training CMs, other MCP personnel, and providers regarding Behavioral Health (BH), including the identification and screening of members' BH needs. She clinically reviews all BH referrals. Ms. Little participates in the writing and revision of the ALTCS case management BH P&Ps. Ms. Little, in collaboration with the Network Development and Contracting Department, monitors the sufficiency of the MCP BH network and facilitates provider education regarding BH. She dedicates 100 percent of her time to ALTCS.

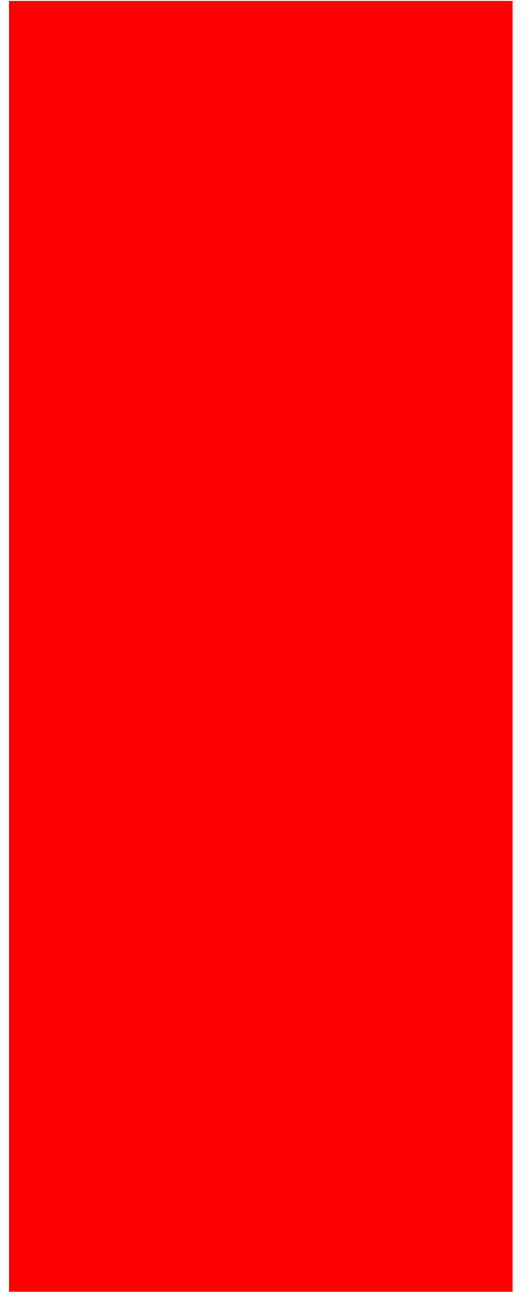
**o. Provider Services Manager, Jennifer Sommers:** is responsible for provider services across all MCP lines of business. She dedicates 20 percent of her time to ALTCS and 80 percent to other MCP product lines. Ms. Sommers monitors consistency of provider services procedures and timely responses across all product lines. She coordinates communications between MCP and our subcontractors, directing sufficient staff to offer providers prompt resolution to problems or inquiries and maintains a sufficient provider network to serve members. She also manages the education, training and communication for the provider network. Ms. Sommers' other MCP duties include the management of provider contracts, provider participation data, service monitoring and contracting, provider notification materials, network adequacy and cost effectiveness. She is supported by two (2) provider services managers and multiple network account managers.

**p. Claims Administrator, Perry Orange, B.S.:** is responsible for administering MCP's comprehensive claims system that adjudicates claims in accordance with state and federal requirements. He supervises MCP's claims volume, dedicating five percent of his time to ALTCS, 45 percent to other MCP product lines, and 50 percent to other Schaller Medicaid business. He administers claims editing protocols (i.e.: cost avoidance) consistent with State and Federal regulations so that MCP claims system meets AHCCCS timely, accuracy, and encounter reporting requirements. He is supported by a Claims Director and four (4) Claims Managers.

**q. Provider Claims Educator, Lynn Kruk, C.P.C.:** reporting to the provider services manager, is responsible for educating contracted and non-contracted providers regarding all provider contract requirements, including proper claims submission, electronic claims transactions and access to MCP provider resources. She dedicates 20 percent of her time to ALTCS and 80 percent to other MCP product lines. Her responsibilities are to fully integrate claims education between MCP's grievance, claims processing and provider services systems to facilitate the exchange of timely information between MCP and providers. Ms. Kruk interfaces with MCP's call center to compile, analyze, and disseminate information from provider calls; identifies trends and guides the development/implementation of strategies to improve provider satisfaction; and communicates frequently with providers by telephone and on-site to facilitate effective communications.

**r. Case Management Administrator/Manager, Chad Corbett, M.P.A.:** is responsible for the Long Term Care Case Management Department, providing day-to-day management and oversight of operations. Mr. Corbett is 100 percent dedicated to ALTCS. He is supported by five (5) managers and 13 supervisors.

5.



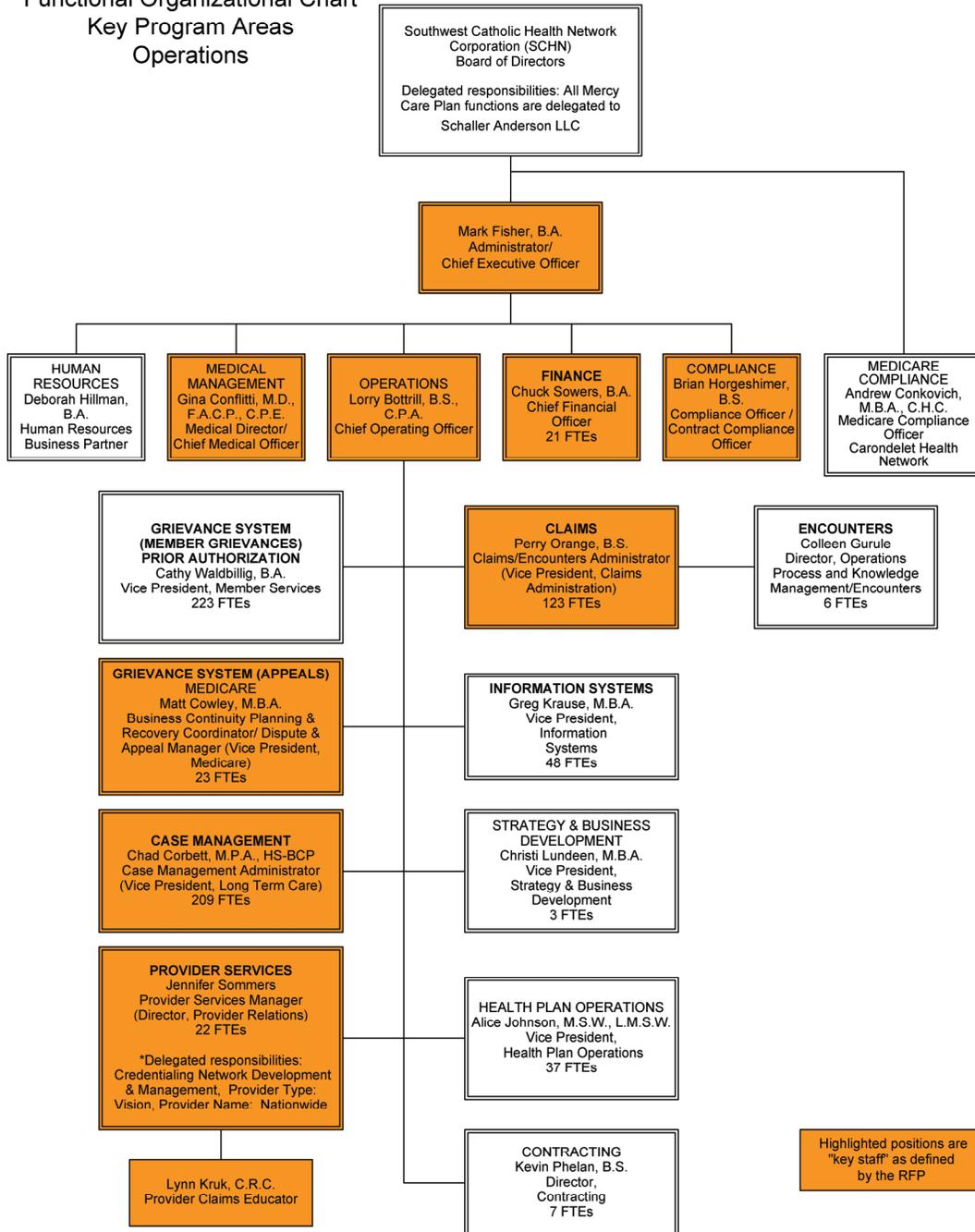


### Question 5 – Organization and Staffing

The following functional organizational charts highlight Mercy Care Plan’s (MCP) key program areas, which are fully integrated into a cohesive structure specifically designed to fulfill all ALTCS program requirements. Our organizational structure provides the flexibility for timely and individualized responses to member and provider needs while also meeting or exceeding AHCCCS’ quality and operational performance standards. Our Administrator/Chief Executive Officer reports directly to the Board of Directors and is responsible for all administration and operations. He is supported by a highly qualified leadership team, which has direct oversight of all functional areas.

Functions subcontracted through delegated agreements, management service agreements and service level agreements are also reflected on the chart: 1) Schaller Anderson, LLC (Schaller), an Aetna company for health plan administration, 2) Express Scripts Inc. for pharmacy benefit management, and 3) delegated credentialing and network agreements. MCP oversees, monitors and evaluates all subcontracted and delegated functions on a continuous basis, and is responsible for meeting all AHCCCS requirements in these areas.

Functional Organizational Chart  
Key Program Areas  
Operations

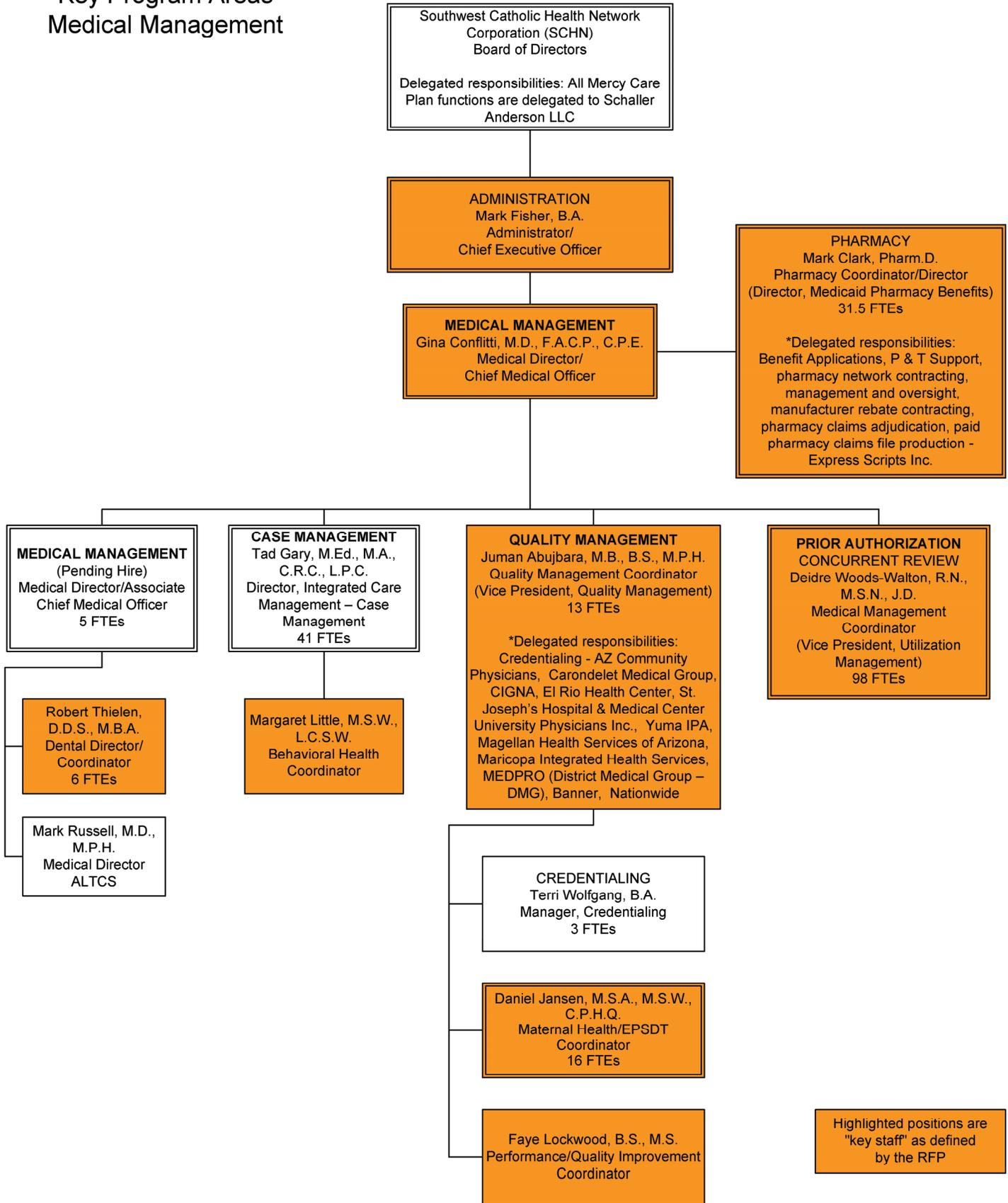




# Functional Organizational Chart

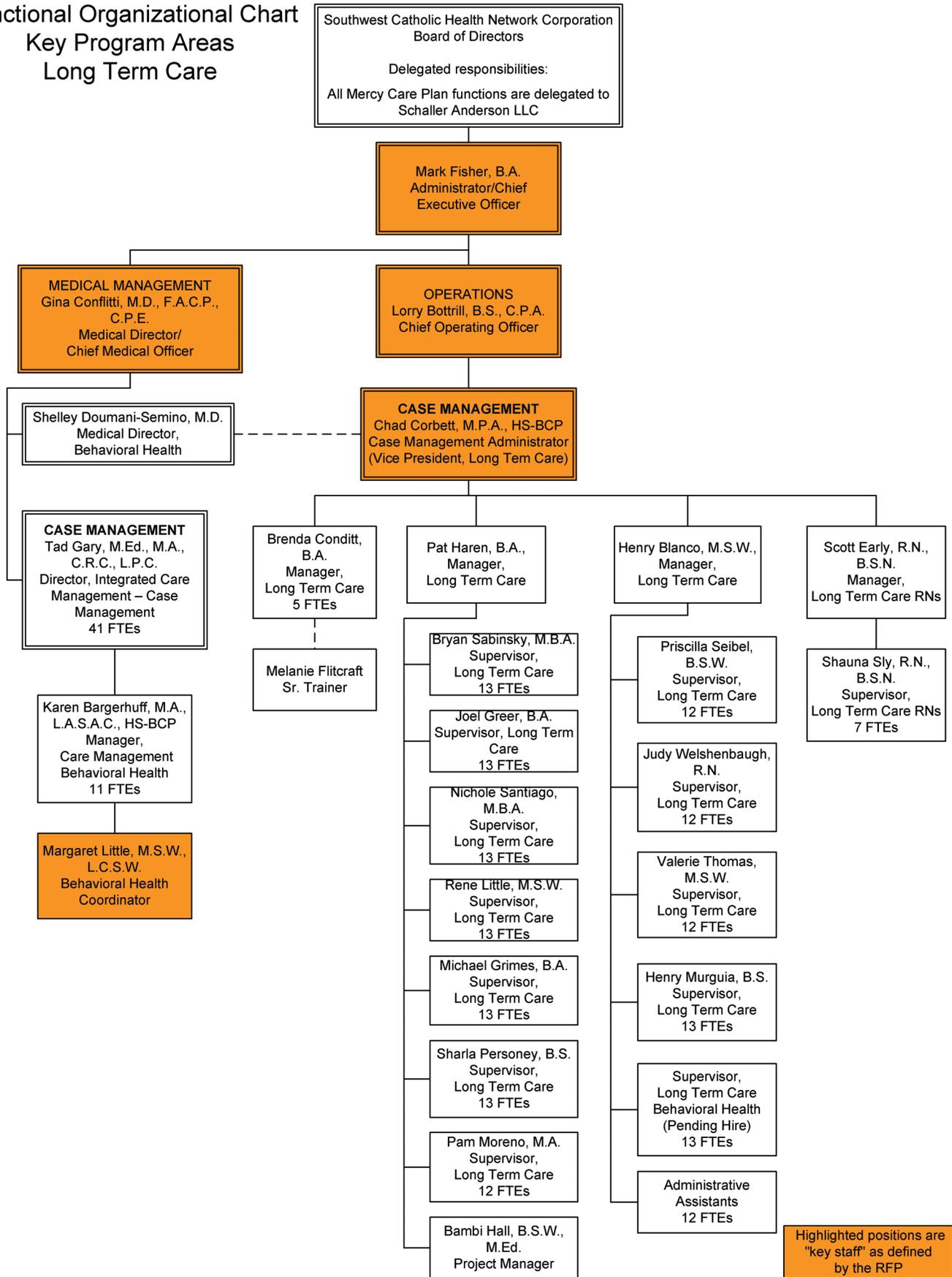
## Key Program Areas

### Medical Management



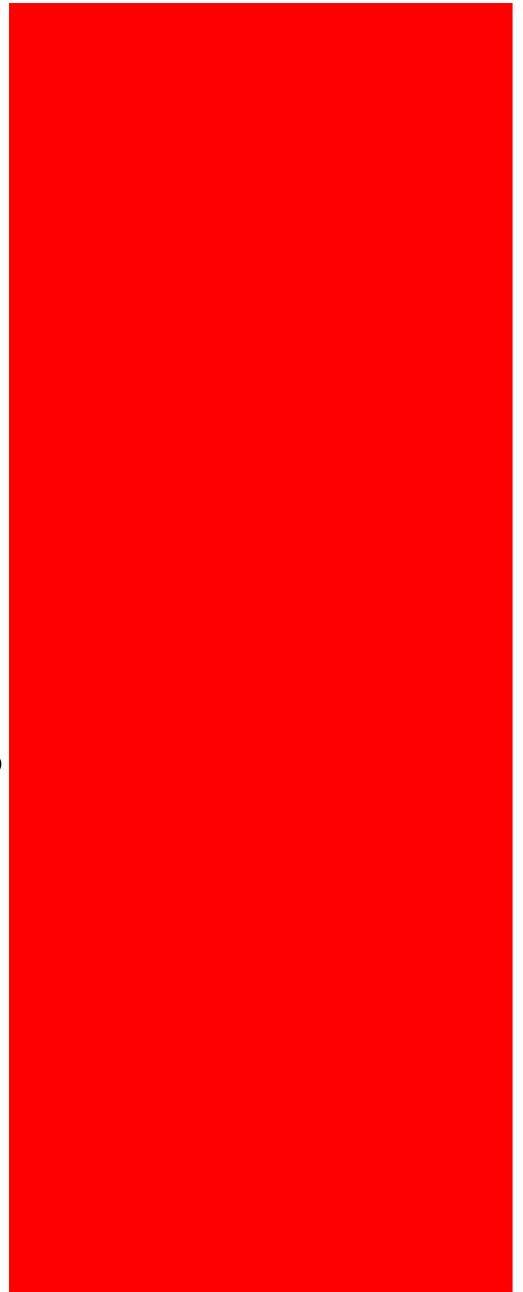


# Functional Organizational Chart Key Program Areas Long Term Care

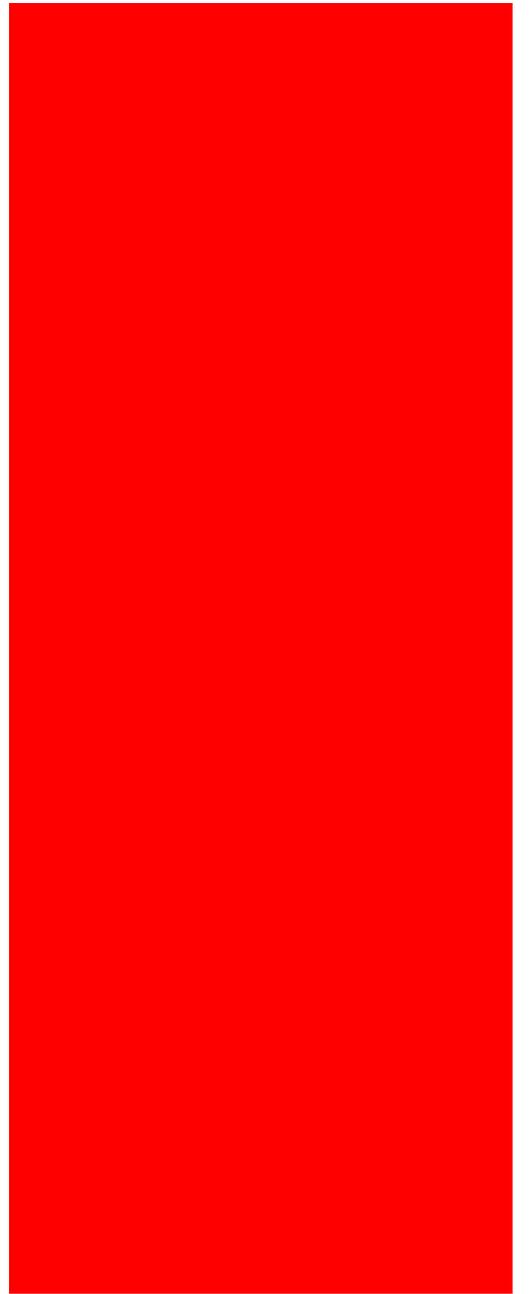


Highlighted positions are "key staff" as defined by the RFP

Sanctions



6.





## Question 6 – Sanctions

Except for the sanctions disclosed herein, there have been no additional sanctions or regulatory actions imposed against Southwest Catholic Health Network Corporation (SCHN). Following is a summary of sanctions imposed since January 1, 2008, including reasons for each sanction and the actions taken to resolve issues and correct any deficiencies. In each instance, Mercy Care Plan (MCP) responded promptly, taking effective action to resolve issues and comply with AHCCCS standards.

### Monetary Sanctions Imposed Since January 1, 2008

Sanction Received	Type of Sanction	Sanction Amount
March 2008	Grievance System Sanction – Acute Care	\$300,000*
April 2008	Notice of Action Sanction – Acute Care	\$10,000
May 2008	Further Sanction for Failure to Comply with Grievance System Requirements – Acute Care	\$150,000*
June 2008	Amendment to Grievance System Sanction – Acute Care	\$100,000
November 2009	Final Omission, Correctness and Timeliness Error Results for the Acute “A” and “B” Encounter Data Validation Studies – Acute Care	\$15,067
January 2010	Violation of Grievance System Guidelines Sanction - ALTCS	\$10,000

*\*Per AHCCCS June 2008 Amendment to Grievance System Sanction, these sanction amounts were held in abeyance pending reporting of MCP performance metrics. MCP promptly implemented actions plans to resolve these issues and the sanctions were never levied.*

### Grievance System Sanction

On March 24, 2008, MCP received an AHCCCS notice imposing a \$300,000 sanction for concerns related to grievance system performance. The sanction letter identified four specific areas of non-compliance: 1) grievance correspondence management, 2) management of overturned claims disputes, 3) claims dispute inventory management, and 4) grievance system data entry. Two of these issues were initially raised in the October notice of concern and the subsequent on-site review. In addition to corrective actions taken in October 2007, we implemented the following:

- Inventory Management Action Plan: 1) created an appeals SWAT team consisting of representatives from the Claims, Appeals, Prior Authorization, Network Development/Provider Services, Business Application Management (BAM) and Provider Data Services (PDS) Departments to review and resolve system issues causing incorrect claim denials; 2) reviewed appeals models and drivers, adjusting staffing levels to accommodate the increase in member appeals and provider claim disputes, and 3) added seven FTEs to handle the increased caseload and hired and trained temporary workers to handle intake and data entry. This action plan included reducing total inventory and effective May 2008, resulted in MCP’s compliance with required processing timelines.
- Grievance Correspondence Management Action Plan: 1) revised Policies and Procedures (P&Ps) for the intake and processing of provider claim disputes to accept bulk and incomplete claim disputes, 2) enhanced training for appeals employees, including review of revised P&Ps, and 3) implemented additional oversight and monitoring of correspondence. This action plan was implemented following the December 2007 site visit and we were in compliance by January 15, 2008.
- Action Plan for Grievance System Data Entry: 1) revised the procedure to assign a dispute category at the point of intake instead of at the time of decision and 2) re-trained intake employees to identify and log the dispute category when the dispute is entered into the Appeals Database. MCP has been fully compliant with the requirement that appeals/claims disputes are acknowledged within five days of receipt since January 15, 2008.

On May 5, 2008, AHCCCS issued a further sanction for Failure to Comply with Grievance System Requirements in the amount of \$150,000 based on findings from an on-site review conducted in April 2008 regarding inventory levels.

On June 19, 2008, AHCCCS notified MCP that the entire Grievance System sanction would be reduced to \$100,000 with the remaining \$350,000 held in abeyance pending performance results for the months August 2007 through January 2008. AHCCCS waived the remainder of the sanction on the condition that MCP meets certain performance measures for the



months of August 2008 through January 2009. MCP successfully met or exceeded the performance metrics and the sanction was reduced to \$100,000 in March 2009.

### **Notice of Action (NOA) Sanction**

On April 7, 2008, MCP received a sanction from AHCCCS in the amount of \$10,000 for an NOA letter that did not meet AHCCCS standards. MCP implemented an action plan to monitor and correct, if necessary, NOAs sent to members. This action plan included the following:

- MCP developed, implemented and staffed a secondary clinical review of all denial letters to facilitate the translation of medical terminology and language to the AHCCCS-required reading level
- MCP implemented prior authorization process changes:
  - Pharmacy Department obtained necessary clinical information at the beginning of the prior authorization (PA) process as opposed to recommending a denial for lack of documentation and referral to the medical director
  - Pharmacy Department must document the clinical decision rationale in sufficient detail, including formulary alternatives
- MCP conducted an end-to-end review of current processes in medical management and pharmacy PA mapping each step of the pharmacy PA process. This end-to-end review included all appropriate actions from initial intake to generation of denial letter (including processes, policies, procedures, hand-offs, communications, and timeframes). Functions of this process included the identification of efficiencies, areas of improvement and staff retraining. In May 2008, medical management developed detailed flow charts of the PA processes, which are currently part of training materials and pharmacy procedures.
  - Developed denial letter language training guide in mid-April; staff training conducted on April 28, 2008.

### **Final Omission, Correctness and Timeliness Error Results for the Acute “A” and “B” Encounter Data Validation Studies**

In 2007 and 2009, AHCCCS completed its review and analysis of professional and facility services reported on Acute “A” Health Plan and Acute “B” Health Plan medical records, respectively. The review was conducted in connection with MCP’s management of certain acute care services provided to AHCCCS enrollees during contract year 2004 (review conducted in 2007) and contract year 2005 (review conducted in 2009), following MCP’s self-reporting of submission errors. The Acute “A” study examined professional services reported on medical records, comparing them to encounter data submitted by MCP. The Acute “B” study examined facility services reported on medical records, comparing them to encounter data submitted by MCP. Three types of data errors were reviewed in both studies; omissions, correctness, and timeliness.

On November 24, 2009, AHCCCS advised MCP that \$15,067 would be withheld from the December capitation payment and instructed MCP to set aside \$42,307 for provider education and training.

MCP amended the encounter corrective action plan to reduce correctness errors for professional services to meet or exceed CMS standards. The CAP was submitted to and accepted by AHCCCS.

### **Violation of Grievance System Guidelines Sanction**

On January 14, 2010, MCP received a sanction from AHCCCS in the amount of \$10,000 for a long term care NOA letter that did not meet AHCCCS standards. MCP implemented an action plan to monitor, and correct, if necessary, NOAs sent to members. The action plan included staff education and training regarding NOA letter language. MCP also reviewed the service approval criteria with clinical staff and medical directors and documented the training.



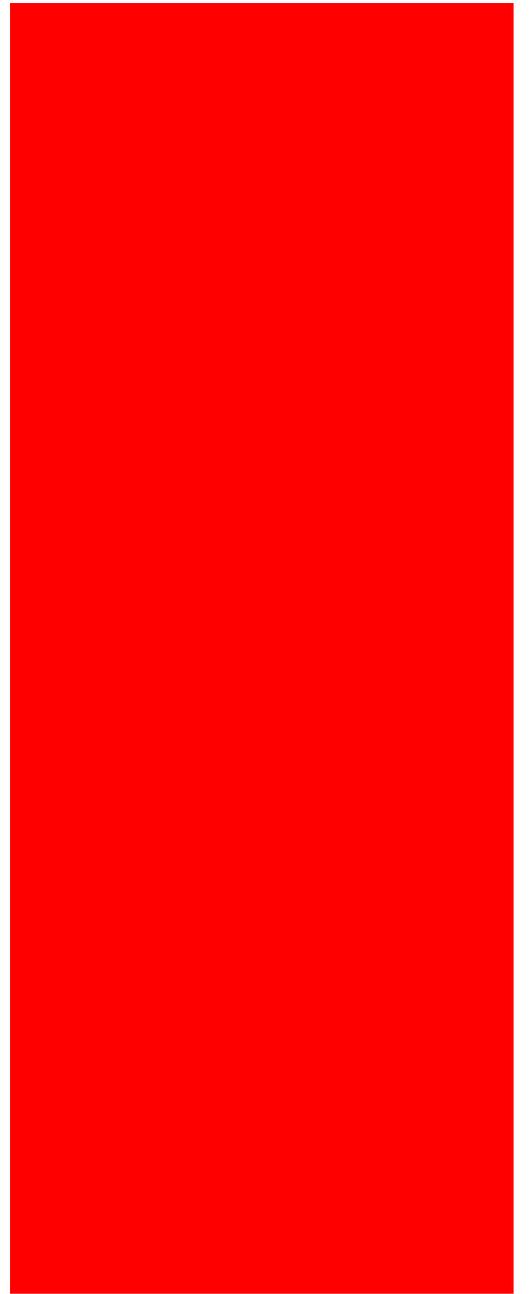
### Final Aged Pended Encounter Sanctions

Pursuant to its Acute Care contract with AHCCCS, MCP is required to resolve all pended encounters within 120 calendar days of the processing date. The following sanctions have been imposed since January 1, 2008 in connection with encounters that were not resolved within the 120-day timeframe. AHCCCS has suspended all monetary sanctions for aged pended encounters since 2007. We continually work to improve our internal processes (e.g., claims adjudication, pharmacy, provider file set-up, and enrollment) to resolve pended encounter issues.

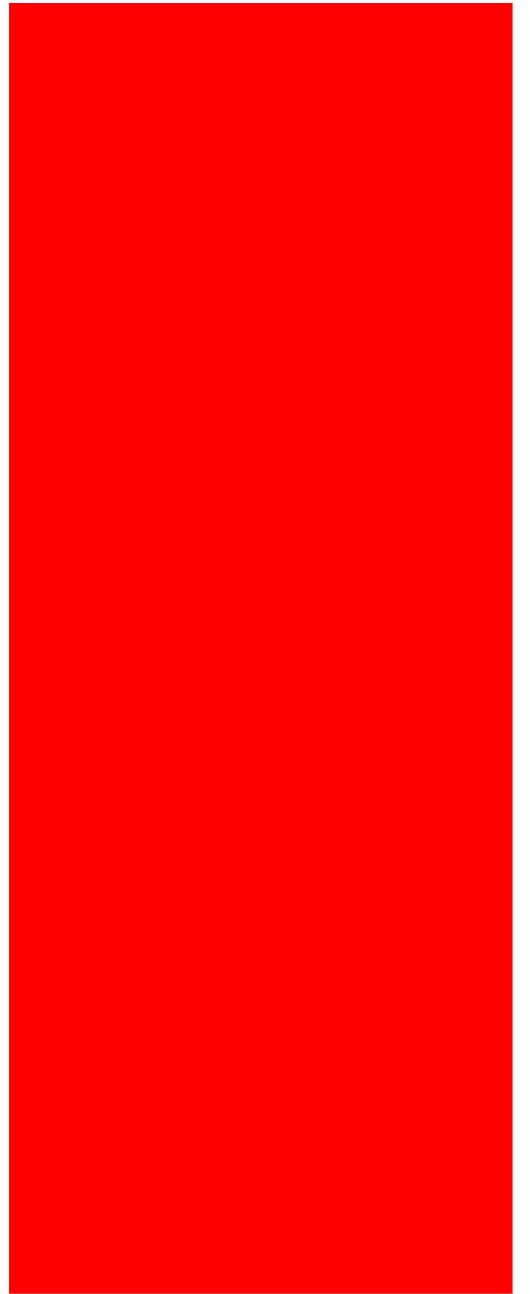
Sanction Received	Type of Sanction	Reporting Period	Sanction Amount
September 2009	Final Aged Pended Encounter Sanction	June 2009	\$256,930*
January 2010	Final Aged Pended Encounter Sanction	September 2009	\$346,740*
March 2010	Final Aged Pended Encounter Sanction	December 2009	\$635,010*
June 2010	Final Aged Pended Encounter Sanction	March 2010	\$743,920*
August 2010	Final Aged Pended Encounter Sanction	June 2010	\$494,560*
December 2010	Final Aged Pended Encounter Sanction	September 2010	\$602,285*
March 2011	Final Aged Pended Encounter Sanction	December 2010	\$873,785*

***\*Sanction was suspended by AHCCCS***

Claims



7.





## Question 7 – Claims

Mercy Care Plan (MCP) through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, and by virtue of our existing contract with AHCCCS maintains a centralized, HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §§ 36-2903 and 2904 and AHCCCS Rules R9-22 Article 7. In fact, QNXT™, the cornerstone of our claims adjudication process, was upgraded to version 3.4 as recently as July 2010 and passed an independent post-migration audit. Future plans include another upgrade to version 4.8 in anticipation of approaching ICD-10 requirements. This HIPAA compliant, rules-based claims adjudication system has processed more than 956,500 claims for our ALTCS line of business from March 1, 2010 through February of 2011 alone. The system is so effective that, for the 10 months ending February 2011, an average of 98.8 percent of claims were finalized within 30 calendar days or less and 99.5 percent within 60 calendar days. Using the Plan-Do-Study-Act (PDSA) protocols, MCP continues to make process improvements that increase our financial and payment accuracy. For example during calendar year 2010, audit results have averaged 99.3 percent (financial) and 98.3 percent (payment) accuracy rates.

Schaller, as part of its management subcontracting agreement, provides full claims administration through a claims management organization. This organization is led by a local director of claims operations; centralizing claim processing functions at Schaller allows MCP to take advantage of economies of scale and quality efficiencies Schaller's claim processing team adjudicates for over a million Medicaid members. MCP's Chief Operating Officer (COO) and Vice President of Health Plan Operations have responsibility and authority over Schaller's claims performance. The COO oversees the system's full compliance with all applicable AHCCCS and federal requirements, maintaining processes that meet claims processing timelines, maximize cost avoidance and minimize claims recoupment. Our Vice President of Health Plan Operations and claims director reviews, approves, dates and signs all claims Policies and Procedures (P&Ps) annually to confirm their agreement with current practices and support continued compliance with applicable AHCCCS standards and requirements.

Schaller's claim system runs on a high-speed Local Area Network (LAN) and Wide Area Network (WAN) and cluster of servers with built in redundancy. This system, including system configuration, provides all necessary computing power, redundancy, and is scalable to meet both enrollment growth and increases in AHCCCS specifications or requirements. Schaller is able to add servers to increase performances vertically and our servers are designed to accept increases in RAM and processing power to grow horizontally. This scalability allows the claims system to match any escalation in volume associated with enrollment growth while maintaining responsiveness, uptime and performance.

### Claims Adjudication

MCP accommodates both electronic and paper claims submission. However, we prefer and actively encourage providers to take advantage of our HIPAA compliant electronic transaction capabilities. These capabilities include electronic claims submission (EDI), Electronic Remittance Advice (ERA) distribution, and Electronic Funds Transfer (EFT). In fact, for the rolling 12 months ending February 2011, an average of 68.8 percent of our ALTCS claims were received through our HIPAA compliant Electronic Data Interchange (EDI) system. For the month of February 2011, we achieved an improved rate of 70.4 percent.

For claims that are received in a paper format, the claim is scanned by Future Vision Technologies, a Schaller vendor. These claim files are then loaded into the QNXT™ system for adjudication. Claims received electronically via one of MCP's clearinghouse partners are loaded directly into the QNXT™ system. Once the electronic files are loaded into the QNXT™ system, a daily batch process is run by the IT Department to auto adjudicate 75.5 percent (average contract year to date) of our ALTCS claims. During the auto adjudication process a series of CCI compliant claims edits are applied based on QNXT™, ClaimCheck® and iHealth software applications. These applications consistently and uniformly apply comprehensive edits to automatically pay, pend, or deny each claim.

As a function of the auto adjudication system, QNXT™ applies claims adjudication logic to reimburse non-participating providers at no more than the established AHCCCS Fee-For-Service rate at the time the service was rendered based on the location of service. This is done by automatically applying AHCCCS' reimbursement schedules and reference files, authorization requirements, provider configuration, and processing rules to the claim as part of the adjudication process.

Claims that fail to auto adjudicate, regardless of reason, are automatically pending for manual review. With exception of those that pend for medical or HCBS review, the manual review is performed by a claims analyst who has experience, knowledge, and training to effectively review and adjudicate the claim. The claims analyst, using a comprehensive set of



claim P&Ps, analyzes and resolves the edits in order to adjudicate the claim. The goal is to resolve all clean claims pending for manual review within 30 days.

Claims pend for medical review due to: 1) outliers, 2) facility authorization mismatch, and 3) reconsiderations based on additional medical information. These claims are pending to a medical management team under the direction of the VP of Medical Management for further review. An RN, with appropriate training and expertise, reviews the claim applying our P&Ps and clinical practice guidelines or similar medical criteria to determine final adjudication status of the claim. A Medical Director is available to assist the RN if necessary. The goal is to resolve all clean claims pending for manual review within 30 calendar days.

Claims pend for HCBS review due to: 1) mismatch of HCBS authorizations, 2) member share of cost clarification, and 3) member room and board clarification. These claims are pending to a specialized HCBS unit, reporting to the VP of Health Plan Operations for further review. An MCP claims analyst, with appropriate training and experience in both case management and claims adjudication, applies MCP's P&Ps to determine final status of the claim. The goal is to resolve all claims pending for manual review with 30 calendar days.

Claims are set to finalized status if they are auto adjudicated or have had a manual intervention that sets the claim to pay. MCP then conducts weekly check runs or makes EFT payments to providers that are sent with a remittance advice for all finalized claims. MCP monitors internal claims reports to make certain claims payment is within AHCCCS timeliness standards. Additional information on our claims adjudication process can be found in an illustration following our response.

### **Coordination of Benefits (COB) and Third Party Liability (TPL)**

It is MCP's standard operating procedure to coordinate benefits with primary insurance or recover payments from other liable parties before applying Medicaid as a source of payment. As 85 percent of ALTCS members are dually eligible, we apply claims specific edits to maximize cost avoidance according to ACOM *Medicare Cost Sharing* policies.

MCP identifies potential COB opportunities through information received from: 1) AHCCCS, 2) Health Management Systems (HMS), 3) internal staff, including CMs, 4) members, 5) claims, and 6) Explanation of Benefits (EOB). Once MCP verifies the Other Insurance (OI), we move to the secondary payor position and adjudicate the claim in accordance with our COB protocols. When a claim is received without an EOB attached and the member's eligibility record identifies OI, we deny the claim. MCP's internal training department provides training to all staff with exposure to claims and encounters, to identify and report COB and TPL opportunities.

Once OI is confirmed, the member's eligibility record is updated. If OI is retroactive, the member's claims history is researched by a claims analyst and any funds paid as primary are recovered.

MCP operates a CMS Medicare special needs plan called Mercy Care Advantage (MCA). For members who are dually eligible and enrolled with MCP and MCA, we auto adjudicate the claim to apply first to the Medicare benefit and then apply the remainder to the Medicaid benefit.

We refer MCP members who may be eligible for Children's Rehabilitative Services (CRS) and who also have private insurance or Medicare coverage to CRS for determination of eligibility for CRS Service. The member benefits profile is updated as necessary, and their care coordination and payment responsibility handled accordingly.

Our member services COB team, utilizing the AHCCCS protocol, reports verified OI that has not been received via AHCCCS files to AHCCCS no later than 10 calendar days from the date of discovery. In addition, AHCCCS is notified of any known change in coverage, including Medicare, via the appropriate technical interface.

For TPL, our standard operating procedure is to "pay and chase". We contract with Recovery Management Services (RMS) to recover payment when applicable. Claims that are received with indication of potential TPL opportunities, based on diagnosis codes, are routed to RMS for recovery. RMS will investigate and pursue recoveries and will return to MCP any recoveries from other payors or insurers. MCP contracts with Health Management Systems (HMS) to recover payments that were made by MCP as primary when the member had OI. The recoveries that HMS pursues on behalf of MCP are for claims payments that are older than a year. HMS works directly with the identified insurance carrier, not the provider.

MCP submits, on a quarterly basis, a summary of our cost avoidance/recovery activity as specified in the AHCCCS Program Integrity Reporting Guide. MCP, applying its standard operating procedures, recovered and avoided over \$72 million in calendar year 2010. A flowchart of our TPL/COB process can be found following our response.



## **Claims Monitoring and Resolution of Deficiencies**

MCP created our Health Plan Operations (HPO) team in April of 2009 to address provider complaints and claims processing issues. The team, led by our Vice President of Health Plan Operations, is responsible for the approval and validation of all system changes related to claims adjudication activities. Under the COO's oversight, the team follows the Plan-Do-Study-Act (PDSA) model for continuous improvement, identifying opportunities for improvement via: 1) monthly meetings on clinical edits, 2) weekly cross functional meetings, 3) claim reports that target, track, and trend claims-related issues, 4) direction and validation of any new system configurations and contracts, 5) regular monitoring of AHCCCS website for required updates, 6) research and resolution of all provider complaints about claims payment, 7) issues identified in claim audits, 8) encounter pends and denials, 9) audits of the system benefits by the HPO Department, and 10) HCBS claims review. The HPO team research all issues identified from the various sources and implement system changes, provider record changes or claims P&Ps changes and corrective action plans, validating all changes, evaluating the results, and repeating the process to promote continuous improvement. All issue or corrective action plans are tracked in a QuickBase database until the issue is resolved. Recent successes include the transition from manual downstream provider file maintenance to an automated front-end process that downloaded provider files directly from AHCCCS, resulting in significantly higher claims processing accuracy.

MCP's provider claims educator supports the HPO team by facilitating the inter-departmental exchange of information and the external exchange of information between these departments and our providers. We then inform providers of, among other things, any issue(s) potentially impacting claim adjudication or any opportunities for provider education.

MCP utilizes a suite of tools, including but not limited to, scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication, and check and remittance advice production/distribution. These tools and reports include, but are not limited to:

Pended Claims and Aging Report – the pended and aging claim report allows management to effectively intervene when and where necessary to improve accurate and timely adjudication of claims. Populated hourly and reviewed daily, the tool presents claims counts and billed dollars by pend reason and claim age, with drill down capabilities to gather for review detailed claims information.

In-Process Claim Reports – MCP's Claims and Health Plan Operations Department each day reviews and monitors the in-process claims report to allow management to effectively track and manage all claims in process so that needed interventions may be applied to improve the accuracy and timeliness of claim adjudication.

Claims Payment Processing Reports – This is a set of retrospective claims adjudication reports that are produced and reviewed weekly to provide claims, health plan operations and finance with data to support reconciliation of claim volume and adjudicated dollars including information to support the reinsurance process.

Monthly Claims Dashboard – This management tool submitted to AHCCCS is used to identify trends related to critical claims metrics. The claims dashboard is reviewed monthly by compliance, encounters, health plan operations, and finance personnel to identify appropriate action plans.

On a daily basis, MCP uses these reports to proactively manage claims workflow. Based on this analysis, health plan operations takes appropriate action to address any trends that indicate a potential issue such as turnaround times or inventory levels for aging claims. It is our standard operating procedure to immediately determine a root cause and develop and implement the appropriate action plan. In the past, these plans have included one or more of the following: 1) system reconfiguration, 2) staff overtime, 3) workload balancing, 4) training of staff and providers, and 5) hiring and training temporary workers to assist with the reduction of claim inventories. Based on our claims volume, we adjust hiring to accommodate any increased trends. Additional information on our claims monitoring and resolution of deficiencies process can be found in an illustration following our response.

## **Claim Quality Reviews and Claim Audits**

We fully audit the work of all new claims analysts, after orientation and training, for at least one month. The audit starts at 100 percent of their work product and decreases to a standard two percent by the fifth week, provided the new claims analyst continues to meet claims accuracy standards. Finally, we review 16 provider calls per claims inquiry representative per month, assessing the quality of service interaction and accuracy of information provided. Individual quality reports are presented to the representative and their supervisor for corrective action (e.g., live call monitoring) if appropriate.



MCP's Claims Audit Department conducts a series of pre-payment audits including: 1) a one percent random sample of system-adjudicated claims, 2) a two percent random sample of all analyst-adjudicated claims, and 3) 100 percent of all claims with billed charges over \$50,000. When pre-payment errors are discovered during these audits, claims are pended for analysis and adjusted as required for final adjudication. If an error in adjudication of the claim indicates a system configuration problem, the issue is routed to health plan operations personnel for further review, analysis, testing, and correction. If adjudication errors are identified relative to manually adjudicated claims, a review of P&Ps and additional training is performed. If our audit identifies a provider billing issue, the information is forwarded to provider services personnel for provider outreach and education as necessary.

To further support quality reviews of claims processing accuracy for acute, HCBS, and Nursing Facility (NF) claims, an independent (does not report to claims leadership) post-payment audit department is responsible for conducting stratified random samples and focused audits of paid and denied claims. The purpose of these activities is to audit compliance of claims adjudication with AHCCCS regulatory requirements, and provider contracts. Audit findings are distributed to the Health Plan Operations Department for root cause analysis and corrective action.

Per the ACOM *Verification of Receipt of Services Policy*, MCP surveys a sample of our membership on a quarterly basis to verify that reimbursed services are, in fact, delivered. Any service authorized but not performed within the allotted time is flagged for investigation by quality management staff.

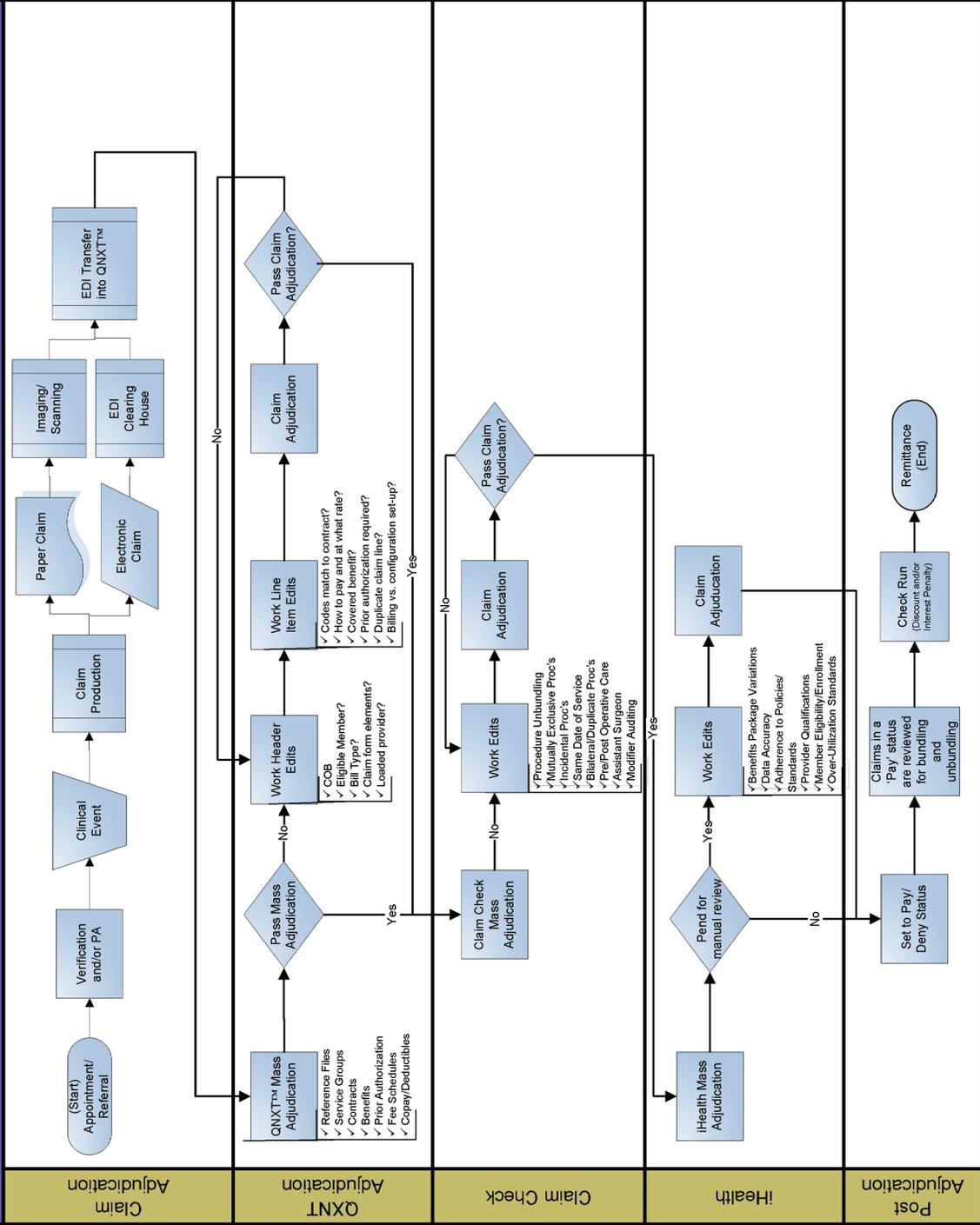
### **Provider Claims Inquiries**

Local provider services staff, including a provider services director, two provider services managers, and Provider Services Representatives (PSRs), to assist providers in resolving problems, respond to provider inquiries, complaints and educate providers. In addition, the Claims Administration Department has full-time Claims Inquiry and Claims Research (CICR) representatives to respond to provider questions, status inquiries, and claims payment issues via our claims inquiry line. The claims inquiry line is staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays), and an automated telephone system allows callers to speak with a representative or leave a detailed message regarding their inquiry. MCP maintains a written claims dispute policy, with additional P&Ps supporting compliance with the associated provisions in attachment B(2) of this RFP.

A record of any provider inquiry, request, or complaint is maintained within QNXT™'s call tracking module. All reported issues are researched, resolved, or responded to within 10 business days, with response timeliness and resolution monitored by way of call management tracking reports. Whenever possible, reported issues are resolved immediately. Issues requiring in-depth research and resolution are submitted to the Health Plan Operations Department. Provider services personnel also respond to inquiries and requests for claims review received through email, fax transmission, or mail. Lastly, network providers can access detailed information via MercyOneSource, our secure HIPAA compliant web portal. An illustration of our provider claim inquiry process can be found below.

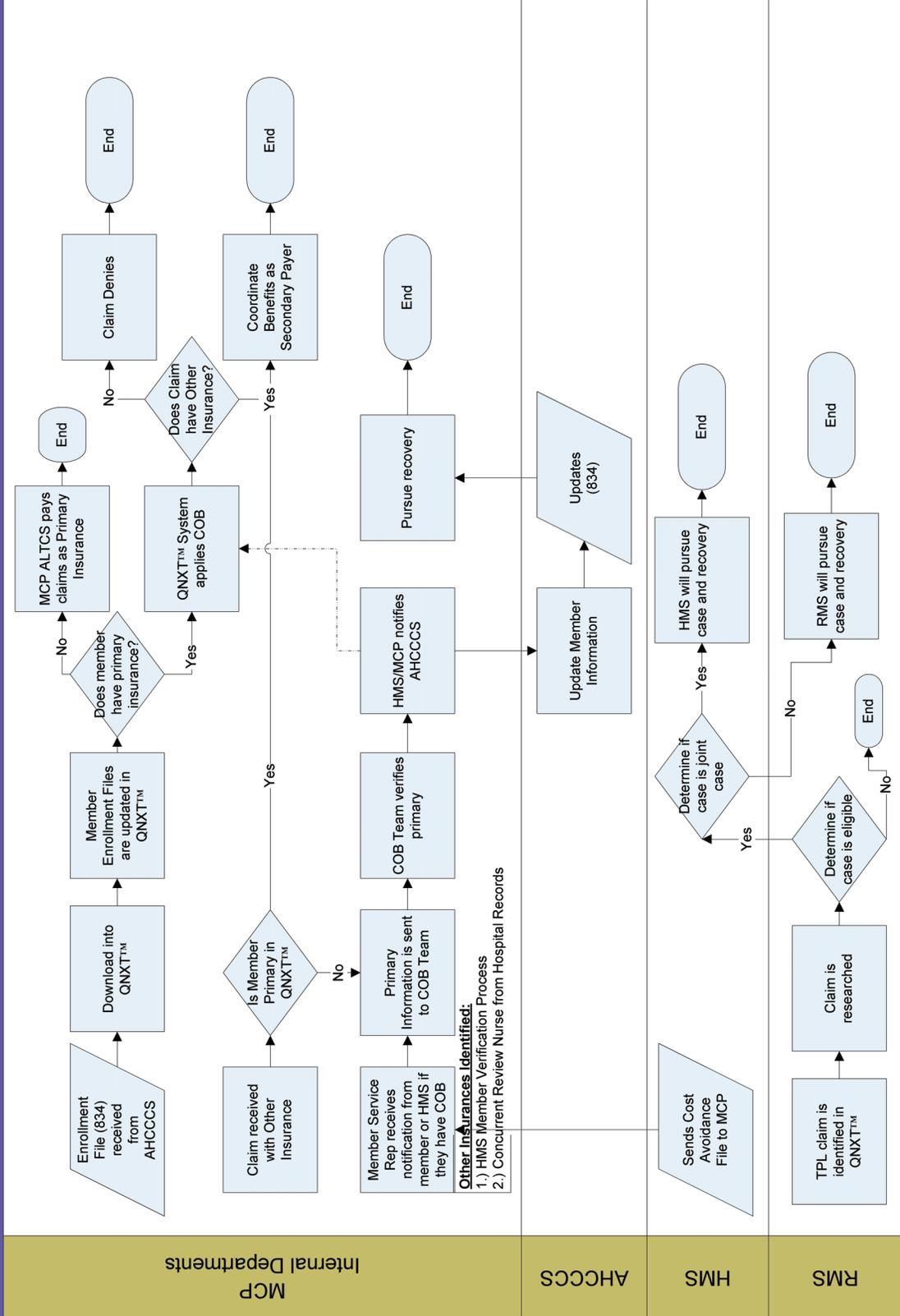
A front and back sample of MCPs Remittance Advice can be found following our flowcharts below.

Life of a Claim

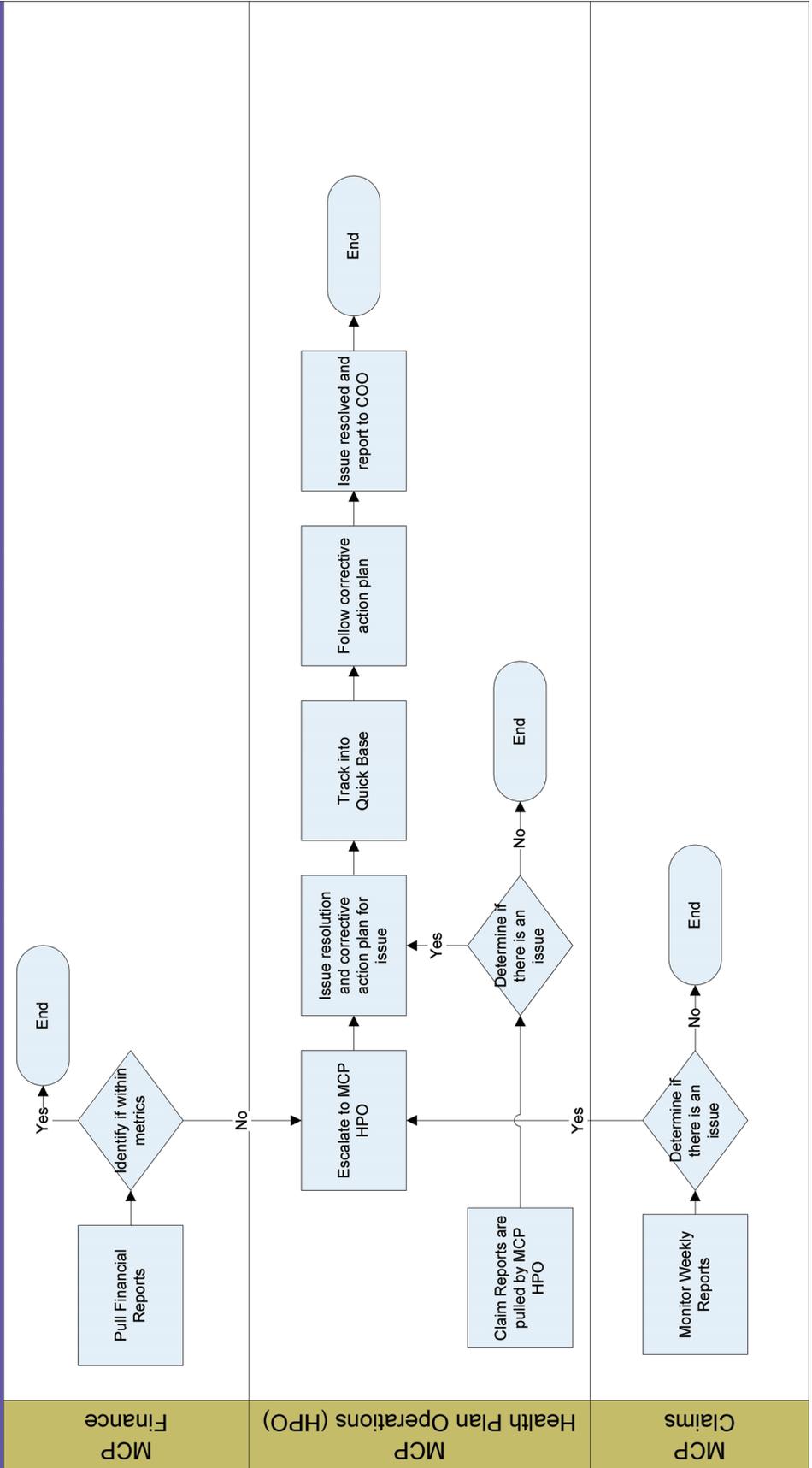




### Third Party Liability (TPL) / Coordination of Benefits (COB)

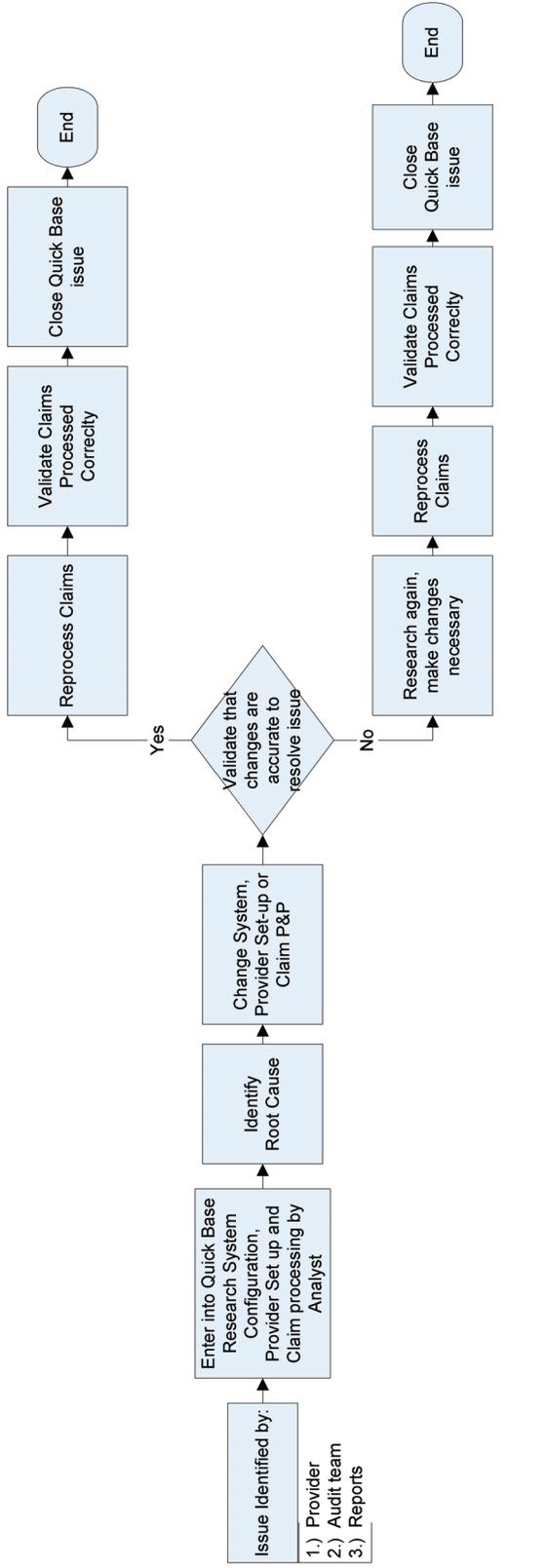


## Claims Monitoring

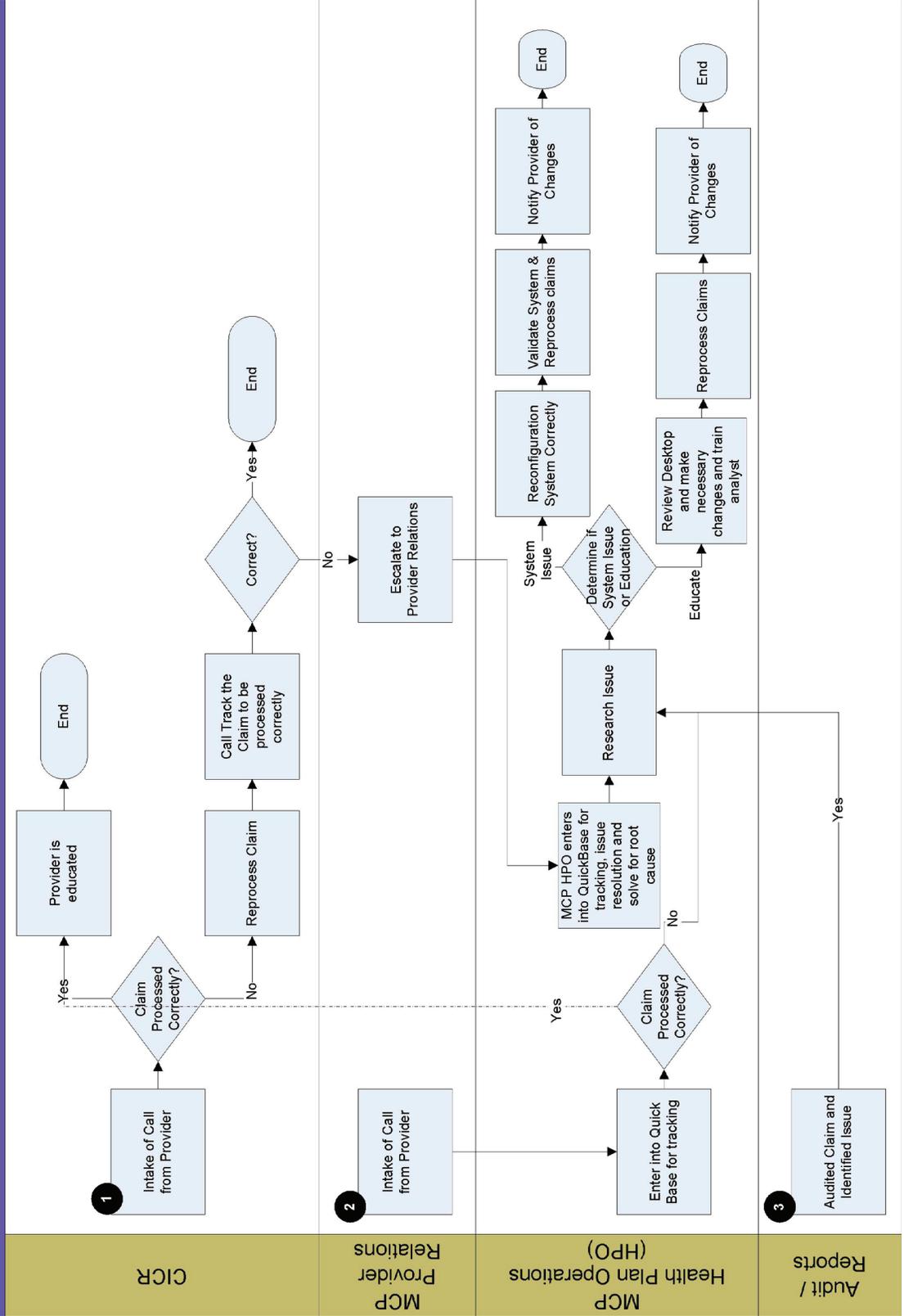


## Resolution & Identification of Deficiencies

MCP  
Health Plan Operations (HPO)



## Provider Claim Inquiry





## Sample Remittance Advice

**Mercy Care Plan**  
 4350 E. Cotton Center Blvd, Bldg D  
 Phoenix, AZ 85040

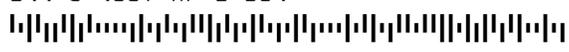
**If you have any questions  
 please contact the Claims Department at  
 (602) 263-3000 or (800) 624-3879**

**Return Service Requested**

**COPY**

3-DIGIT 850

199 5.9687 AF 1.389



ACACIA INTERNAL MEDICINE SPECIA 2  
 20040 N 19TH AVE STE A  
 STE A  
 PHOENIX, AZ 85027-4256



<b>Remit Date:</b>	03/15/2011
<b>Beginning Balance:</b>	0.00
<b>Processed Amount:</b>	384.52
<b>Discount/Penalty:</b>	0.00
<b>Net Amount:</b>	384.52
<b>Refund Amount:</b>	0.00
<b>Amount Recouped:</b>	0.00
<b>Amount Paid:</b>	384.52
<b>Ending Balance:</b>	0.00
<b>EFT Reference #:</b>	
<b>EFT Amount:</b>	384.52
<b>Bank Account:</b>	XXXXXXXXXXXX4077

**TIN:**  
**Benefit Plan:** ALTCS General

ACACIA INTERNAL MEDICINE SPECIALISTS

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	02/21/11	99214			FFS	1	200.00	0.00	81.90	0.00	0.00	81.90	0.00	81.90
<b>Claim Totals</b>							200.00	0.00	81.90	0.00	0.00	81.90	0.00	81.90

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	01/14/11	99214			FFS	1	200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38
<b>Claim Totals</b>							200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	02/16/11	99214			FFS	1	200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38
<b>Claim Totals</b>							200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	02/16/11	99214			FFS	1	200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38
<b>Claim Totals</b>							200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

**Mercy Care Plan**  
 4350 E. Cotton Center Blvd, Bldg D  
 Phoenix, AZ 85040

**If you have any questions  
 please contact the Claims Department at  
 (602) 263-3000 or (800) 624-3879**



**COPY**

ACACIA INTERNAL MEDICINE SPECIALISTS  
 TIN:

Remit Date: 03/15/2011  
 EFT Reference #:  
 Benefit Plan: ALTCS General

Patient:		Patient Acct #:					Claim Status: PAID							
Member ID:		Authorization ID:					Claim#:							
Date of Birth:		Provider:					Refund Amount: 0.00							
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	02/16/11	99214	25		FFS	1	200.00	0.00	16.38	0.00	65.52	16.38	0.00	16.38
2	02/16/11	J3420			FFS	1	10.00	0.00	0.06	0.00	0.23	0.06	0.00	0.06
3	02/16/11	96372			FFS	1	37.00	0.00	4.00	0.00	15.99	4.00	0.00	4.00
<b>Claim Totals</b>							247.00	0.00	20.44	0.00	81.74	20.44	0.00	20.44

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

Patient:		Patient Acct #:					Claim Status: PAID							
Member ID:		Authorization ID:					Claim#:							
Date of Birth:		Provider:					Refund Amount: 0.00							
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	02/16/11	99214			FFS	1	200.00	0.00	80.46	0.00	1.44	80.46	0.00	80.46
<b>Claim Totals</b>							200.00	0.00	80.46	0.00	1.44	80.46	0.00	80.46

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

Patient:		Patient Acct #:					Claim Status: PAID							
Member ID:		Authorization ID:					Claim#:							
Date of Birth:		Provider:					Refund Amount: 0.00							
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	11/18/10	99335			FFS	1	180.00	0.00	17.87	0.00	60.02	17.87	0.00	17.87
<b>Claim Totals</b>							180.00	0.00	17.87	0.00	60.02	17.87	0.00	17.87

Patient:		Patient Acct #:					Claim Status: PAID							
Member ID:		Authorization ID:					Claim#:							
Date of Birth:		Provider:					Refund Amount: 0.00							
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	10/28/10	99318			FFS	1	130.00	0.00	17.58	0.00	57.29	17.58	0.00	17.58
<b>Claim Totals</b>							130.00	0.00	17.58	0.00	57.29	17.58	0.00	17.58

Patient:		Patient Acct #:					Claim Status: PAID							
Member ID:		Authorization ID:					Claim#:							
Date of Birth:		Provider:					Refund Amount: 0.00							
L <sub>i</sub> n <sub>e</sub>	Dates of Service (From - Thru)	Serv Code	Mod Code	Rev Code	FFS/ CAP	Units	Billed Amount	Disallowed	Allowable Amount	Co-Pay	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
1	09/23/10	99335			FFS	1	180.00	0.00	17.87	0.00	58.85	17.87	0.00	17.87
<b>Claim Totals</b>							180.00	0.00	17.87	0.00	58.85	17.87	0.00	17.87

**Mercy Care Plan**  
 4350 E. Cotton Center Blvd, Bldg D  
 Phoenix, AZ 85040

**If you have any questions  
 please contact the Claims Department at  
 (602) 263-3000 or (800) 624-3879**



COPY

ACACIA INTERNAL MEDICINE SPECIALISTS  
 TIN:

Remit Date: 03/15/2011  
 EFT Reference #:  
 Benefit Plan: ALTCS General

10 OF 33  
 ENV 199

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
<b>L<sub>i</sub> n<sub>e</sub></b>	<b>Dates of Service (From - Thru)</b>	<b>Serv Code</b>	<b>Mod Code</b>	<b>Rev Code</b>	<b>FFS/ CAP</b>	<b>Units</b>	<b>Billed Amount</b>	<b>Disallowed</b>	<b>Allowable Amount</b>	<b>Co-Pay</b>	<b>COB Paid</b>	<b>Processed Amount</b>	<b>Discount/ Penalty</b>	<b>Net Amount</b>
1	01/06/11	99335			FFS	1	180.00	0.00	77.89	0.00	0.00	77.89	0.00	77.89
<b>Claim Totals</b>							180.00	0.00	77.89	0.00	0.00	77.89	0.00	77.89

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
<b>L<sub>i</sub> n<sub>e</sub></b>	<b>Dates of Service (From - Thru)</b>	<b>Serv Code</b>	<b>Mod Code</b>	<b>Rev Code</b>	<b>FFS/ CAP</b>	<b>Units</b>	<b>Billed Amount</b>	<b>Disallowed</b>	<b>Allowable Amount</b>	<b>Co-Pay</b>	<b>COB Paid</b>	<b>Processed Amount</b>	<b>Discount/ Penalty</b>	<b>Net Amount</b>
1	02/16/11	99308			FFS	1	128.00	0.00	11.05	0.00	44.22	11.05	0.00	11.05
<b>Claim Totals</b>							128.00	0.00	11.05	0.00	44.22	11.05	0.00	11.05

**Code/Description**

23 - Payment adjusted because charges have been paid by another payer

<b>Patient:</b>		<b>Patient Acct #:</b>				<b>Claim Status: PAID</b>								
<b>Member ID:</b>		<b>Authorization ID:</b>				<b>Claim#:</b>								
<b>Date of Birth:</b>		<b>Provider:</b>				<b>Refund Amount: 0.00</b>								
<b>L<sub>i</sub> n<sub>e</sub></b>	<b>Dates of Service (From - Thru)</b>	<b>Serv Code</b>	<b>Mod Code</b>	<b>Rev Code</b>	<b>FFS/ CAP</b>	<b>Units</b>	<b>Billed Amount</b>	<b>Disallowed</b>	<b>Allowable Amount</b>	<b>Co-Pay</b>	<b>COB Paid</b>	<b>Processed Amount</b>	<b>Discount/ Penalty</b>	<b>Net Amount</b>
1	12/08/10	G0180			FFS	1	104.00	0.00	10.32	0.00	37.94	10.32	0.00	10.32
<b>Claim Totals</b>							104.00	0.00	10.32	0.00	37.94	10.32	0.00	10.32

<b>Remit Totals</b>	<b>Billed Amount</b>	<b>Disallowed</b>	<b>Allowable Amount</b>	<b>Co-Pay</b>	<b>COB Paid</b>	<b>Processed Amount</b>	<b>Discount/ Penalty</b>	<b>Net Amount</b>
	2,149.00	0.00	384.52	0.00	538.06	384.52	0.00	384.52



**Mercy Care Plan**  
4350 E. Cotton Center Blvd, Bldg D  
Phoenix, AZ 85040

**If you have any questions  
please contact the Claims Department at  
(602) 263-3000 or (800) 624-3879**



COPY

ACACIA INTERNAL MEDICINE SPECIALISTS

**TIN:**

**Remit Date:** 03/15/2011

**EFT Reference #:**

**Benefit Plan:** ALTCS General

**Messages**

Mercy Care Plan offers the following resources for additional information and assistance:

(1) In accordance with Arizona Administrative Codes (AAC) R9-22-702, R9-28-702 and R9-31-702, "A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person, or a person acting on behalf of a member or eligible person, for any covered service except to collect an authorized co-payment or payment for additional services." This means that eligible members cannot be billed for covered services. Members must not be billed for services that are not paid due to the failure of the provider to comply with Mercy Care Plan authorization or billing requirements."

(2) If you would like to report healthcare fraud related issues, please call the toll-free hotline at 1-800-338-6361 or contact us by email at [aetnasiu@aetna.com](mailto:aetnasiu@aetna.com).

(3) For Claims Inquiry please go to our web site at [www.mercycareplan.com](http://www.mercycareplan.com) or call (602) 263-3000 or (800) 624-3879 to verify that your claim was processed correctly or for clarification of information before initiating a claims dispute.

(4) For Claims Resubmission and Reconsideration: Mark at the top of the claim "resubmission" or "reconsideration" and submit:

- Nature of request;
- Member's name, date of birth, member ID number;
- Service/admission date;
- Location of treatment, service, or procedure;
- Documentation supporting request;
- Copy of claim; and
- Copy of the remittance advice on which the claim was denied or incorrectly paid.

Request for Resubmission and Reconsideration  
MUST be sent to:

Mercy Care Plan  
Attn: Claims R & R  
P.O. Box 52089  
Phoenix, AZ 85072-2089

Please note: You have 12 months from date of service or eligibility posting, whichever is later, to file a resubmission or request for reconsideration of a claim. If you have any questions please contact Claims Inquiry at (602) 263-3000 or (800) 624-3879.

(5) Claim Disputes:

The provider must follow all applicable laws, policies and contractual requirements when filing a claim dispute. According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by Mercy Care Plan within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later [A.R.S §36-2903.01(B)(4) and A.A.C. R9-34-405(A)].

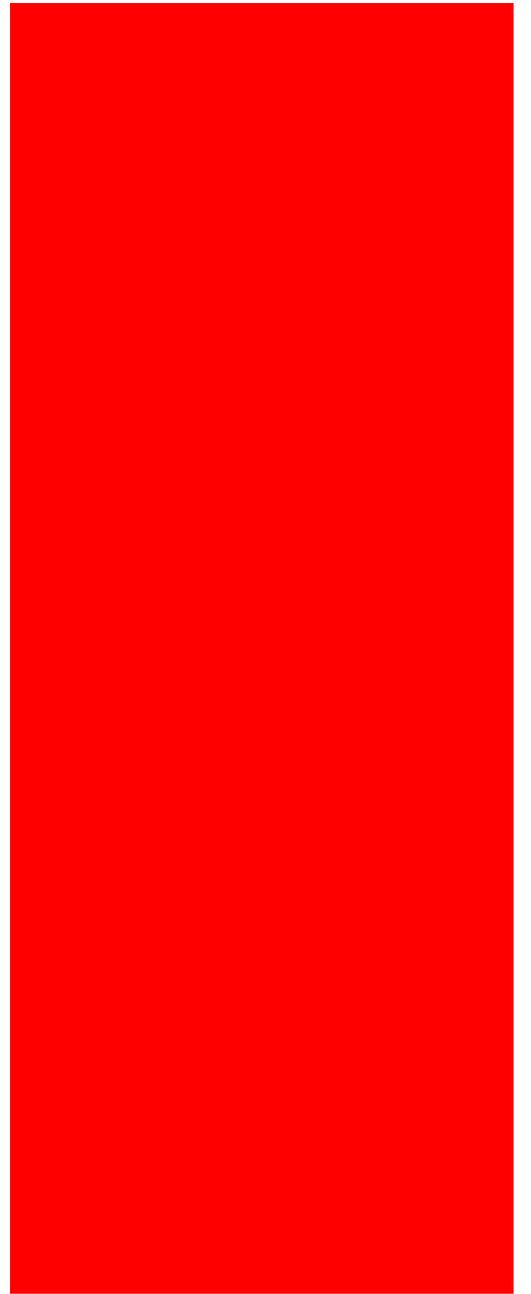
To expedite the processing of a claim dispute, please include the following information:

- Member's name, date of birth, AHCCCS ID number;
- Service/admission dates(s);
- Location of treatment, service or procedure;
- Clinical information and/or medical records/documentations supporting the request;
- Copy of the original claim; and
- Copy of the Mercy Care remittance advice on which the claim denied or incorrectly paid

Claim disputes MUST be sent to:

Mercy Care Plan  
Attn: Appeals Department  
4350 E. Cotton Center Blvd. Bldg. D  
Phoenix, AZ 85040

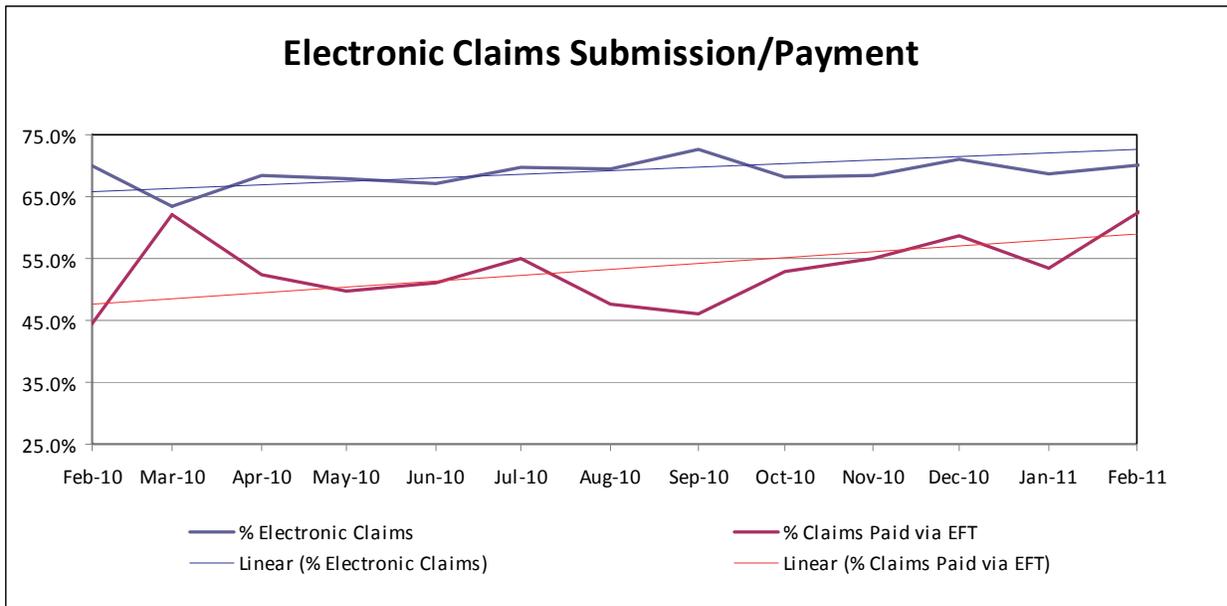
8.



## Question 8 – Claims

Mercy Care Plan (MCP), an ALTCS contractor for over 10 years, continually looks for opportunities to improve service to our participating and non-participating providers. MCP accepts and generates HIPAA compliant electronic transactions from/to any provider interested in and capable of electronic claims submission [i.e. Electronic Data Interchange (EDI)] or electronic remittance advice (ERA). We also support claims payment via electronic funds transfer (EFT).

As illustrated below, continued promotion of MCP’s EDI and ERA services resulted in a significant increase in EDI claims submissions between February 2010 and February 2011. EDI claims submissions accounted for 70.4 percent of total claims submissions between February 2010 and February 2011. In January 2011, MCP’s Provider Services Department implemented an internal action plan to increase provider education and outreach to improve provider’s utilization of EFT payment transactions. By February 2011, MCP’s EFT transactions were at 65.3 percent, which exceeds the AHCCCS minimum standard. The Provider Services Department reports progress on the action plan to the Chief Operating Officer (COO) on a monthly basis. These reports include modifications needed to the internal action plan to improve compliance.



MCP’s promotion of these services will remain a priority throughout the term of this contract, and MCP anticipates exceeding AHCCCS’ requirements. MCP takes advantage of any provider education or outreach opportunity to inform providers of the associated benefits and requirements of EDI and EFT transactions. MCP, by 3rd quarter of 2011, will add a message on provider remittance advices reminding providers of the EFT option and to contact our provider claims educator if they have any questions regarding the initiation or set up of EDI, ERA, or EFT.

On a quarterly basis, MCP Provider Service Representatives (PSRs) conduct site training for network providers which may include: 1) initial on-site orientation, 2) follow-up visits with established providers, and 3) focused trainings as indicated by provider request, performance, complaints, or member grievances. During these face-to-face training sessions, our PSRs promote the availability of EDI and EFT transactions as part of MCP’s ongoing provider education and outreach program.

Listed below are some of highlights of the provider EDI, ERA, and EFT discussion points.

	Benefits	Requirements
<b>EDI</b>	<ul style="list-style-type: none"> <li>Accurate submission and immediate notification of submission errors from the EDI clearinghouse</li> <li>Faster processing resulting in prompt payment</li> <li>Ability to track claim processing status via Mercy Care Plan website</li> </ul>	<ul style="list-style-type: none"> <li>Agreement with an electronic clearinghouse</li> <li>Software to transmit electronic claims</li> </ul>

	Benefits	Requirements
	<ul style="list-style-type: none"> <li>MCP pays certain EDI transaction fees, depending on the vendor</li> </ul>	
<b>EFT</b>	<ul style="list-style-type: none"> <li>Automatic deposit of payment</li> <li>Faster receipt of payment</li> <li>No paper checks to deposit</li> <li>Immediate verification of payment</li> </ul>	<ul style="list-style-type: none"> <li>Preferred that the provider be EDI enabled</li> <li>Bank account number</li> <li>A voided check/savings account deposit slip</li> <li>Signed EFT Authorization Form</li> </ul>
<b>ERA</b>	<ul style="list-style-type: none"> <li>Electronic file of processed claims from MCP</li> <li>Electronically posts payments to the provider's practice management system</li> <li>Faster reconciliation of account receivables</li> <li>Simplified reconciliation process</li> </ul>	<ul style="list-style-type: none"> <li>Preferred that the be provider be both EDI and EFT enabled</li> <li>Ability to accept HIPAA standard 835 electronic remit transactions</li> </ul>

MCP utilizes informational and educational tools to support our provider initiatives promoting and advancing EDI and EFT. These tools include:

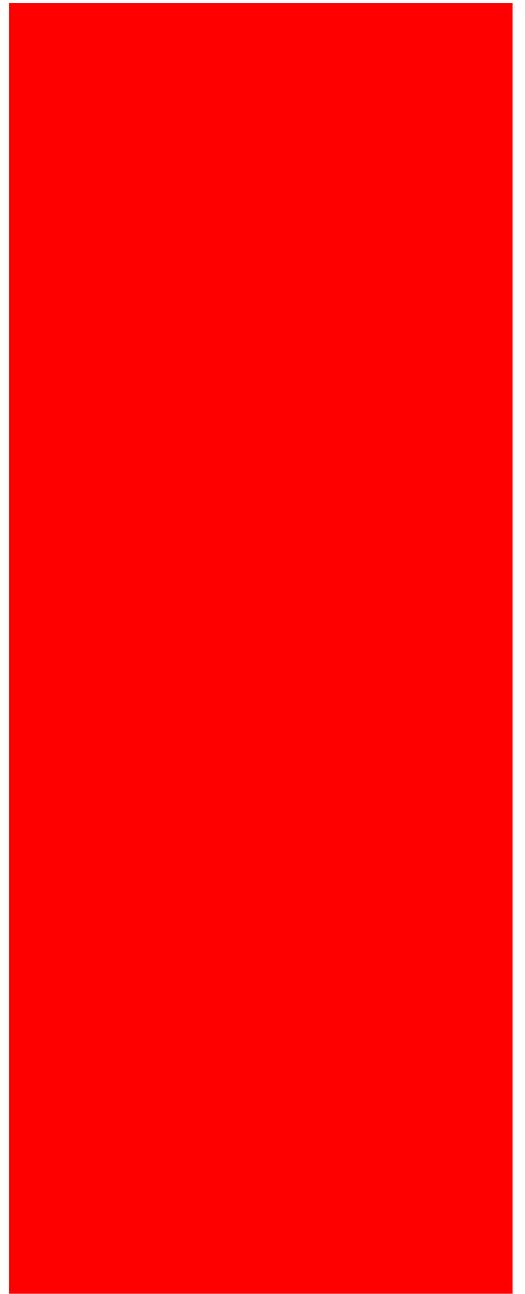
- Provider Manual – MCP’s provider manual contains information and instructions explaining how providers may obtain EDI, ERA and EFT services.
- Provider Claim Reference Materials – MCP’s claims reference materials include information about MCP EDI vendors and contact information
- Provider Newsletters –electronic services transactions remain a standing item in MCP’s provider newsletters. Continuing throughout the term of this contract, newsletters will focus on the advantages of EDI, ERA and EFT.
- Website – MCP’s provider website offers other EDI, ERA, and EFT resources such as enrollment forms, vendor contact information and system requirements,
- In addition to the resources named above, MCP’s EDI vendors offer support to providers that utilize these services, including technical support, training and tutorials.

The Provider Services Manager reviews EFT and EDI statistics reported on the monthly AHCCCS claims dashboard. The MCP Finance Department produces a report identifying providers submitting high-volumes of paper claims and high-dollar provider payments not made via EFT. The Provider Services Manager reviews the Claims Data Summary report to identify providers for outreach opportunities and outliers or trends with existing EDI/ETF providers. Additional education and outreach may be initiated if existing EDI/ETF providers fall below submission or payment averages.

MCP submits an annual report to AHCCCS detailing our action plan including measureable goals and actions to increase EFT and EDI. The report includes an analysis of interventions, identified barriers to goals, and the action/tasks MCP will implement to achieve and maintain these goals

MCP recognizes some of the unique challenges of the Pima County assisted living homes, facilities, and adult foster care providers who may not have been previously disposed to EFT or EDI capabilities. Noting that many of these providers are accustomed to roster billing in Pima County, MCP has entered into a strategic arrangement with GE Healthcare that will provide them with access to billing software through a web-based portal. MCP and GE will create provider education that will guide providers through the process of EDI. Our provider service reps will work with these providers on a regular basis until they have established a sense of familiarity and evidence of proficiency is attained.

9.



## Question 9 – Claims

Mercy Care Plan (MCP) through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, maintains claims processing activities that include the application of comprehensive clinical and data related edits supporting the efficient, effective adjudication of claims. QNXT™, our core claims adjudication application has data related edits configured within its software and is supplemented by two clinical claims editing solutions. The first of the two clinical claims editing solutions, iHealth Technologies’ (iHT) Integrated Claims Management Services (ICM Services), applies select payment policies from one of the industry’s most comprehensive correct coding and Medical Policy content libraries. The second, McKesson’s ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power.

The three applications utilize historic and “new day” claims information to detect questionable billing practices, such as new patient billing codes submitted by the same provider for the same member within a six month period. These applications also assist in identifying fraudulent and abusive billing patterns by generating reports that indicate trending and outliers of provider billing behavior. Inbound claims are initially checked for items such as member eligibility, covered services, excessive or unusual services for gender or age (e.g. “medically unlikely”), duplication of services, prior authorization, invalid procedure codes, and duplicate claims. Claims billed in excess of \$50,000 are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Professional claims (HCFA 1500s) that reach an adjudicated status of “Pay” are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements [e.g., American Medical Association (AMA)], and maximum unit requirements supplied by AHCCCS, with recommendations applied during an automatic re-adjudication process. Other methodologies utilized throughout the auto-adjudication process include, but are not limited to, Multiple Surgical Reductions and Global Day E & M Bundling.

### **QNXT™ Data Edits**

QNXT™ has over 400 business rules that MCP configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against AHCCCS standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.

Examples of data edits specific to QNXT™ include the following:

#### ***Benefits Package Variations***

QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

#### ***Data Accuracy***

QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.

#### ***Adherence to Prior Authorization Requirements***

QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

#### ***Provider Qualifications***

QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to “Pay” for billing appropriateness by specialty.



QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.

### ***Member Eligibility and Enrollment***

QNXT™ validates the date of service against the member’s enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.

### ***Duplicate Billing Logic***

QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against MCP paying for services rendered by the same physician or other physicians within the same provider group

### ***ClaimCheck® Edits***

ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with MCP’s P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre and Post-operative care
- Assistant Surgeon
- Modifier Auditing
- Medically Unlikely

MCP offers network providers access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand MCP’s clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through MCP’s web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.

### ***iHealth Edits***

iHealth clinically edits claims to assist MCP to promote the proper and fair payment of professional DME and outpatient claims.

### ***Coding Accuracy***

If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).

### ***Duplicate Billing Logic***

In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against MCP paying for services rendered by the same physician or other physicians within the same provider group

### ***Durable Medical Equipment (DME) Editing***

iHealth Technologies’ (iHT) performs edits related to select DME payment policies that align with ALTCS covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.

### ***Procedure Code Guidelines - iHealth***

MCP follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. iHT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct

vaccine/toxoid codes, MCP would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

#### ***Procedure Code Definition Policies - iHealth***

iHT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.

#### ***Fraud & Abuse***

MCP's Fraud and Abuse Department, under the direction of the VP of Health Plan Operations, utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting additional analysis and investigation. MCP fraud and abuse personnel work in conjunction with MCP's Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If MCP discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to AHCCCS within 10 business days of discovery by completing and submitting the confidential AHCCCS Referral for Preliminary Investigation form.

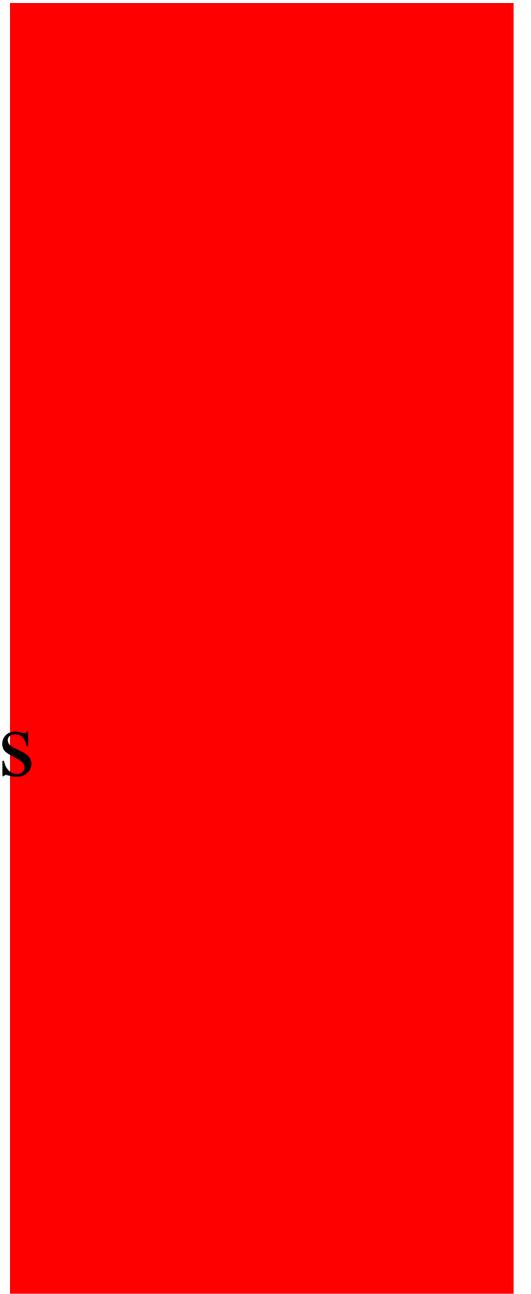
#### ***Claims Education***

MCP's provider claims educator works to educate contracted and non-contracted providers on appropriate claims submission requirements, coding updates and available resources, such as provider manuals, websites, fee schedules, etc. In addition, the provider claims educator will participate in an AHCCCS workgroup tasked with developing uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, sharing information with providers accordingly.

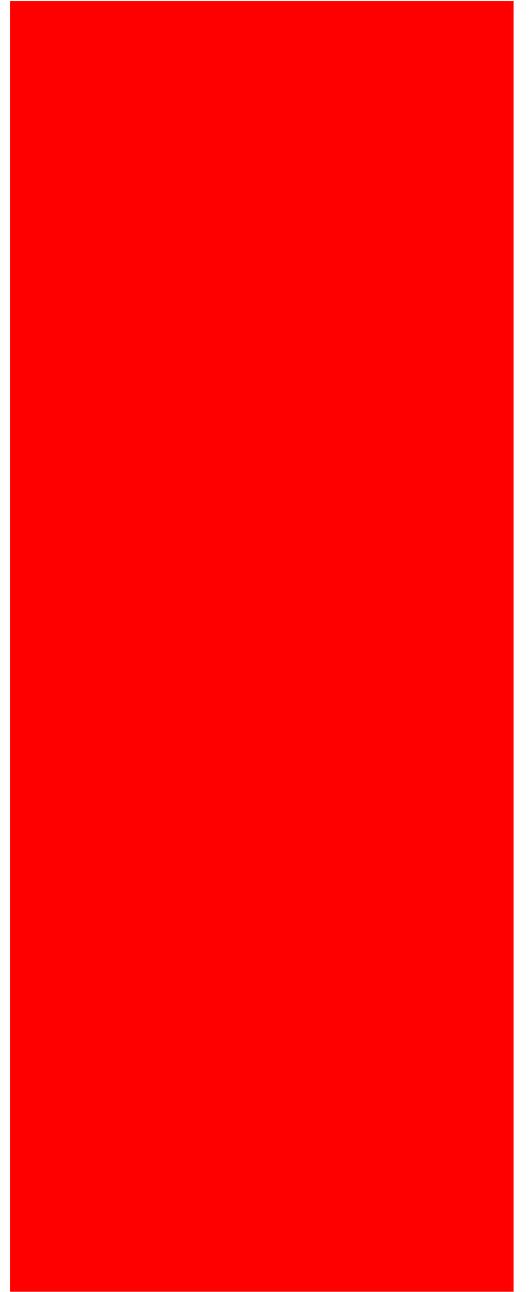
#### ***Claims Editing Results***

In calendar year 2010, due to our robust and comprehensive claims editing programs, MCP cost avoided/recovered in excess of seventeen million dollars related to the ALTCS program.

Encounters

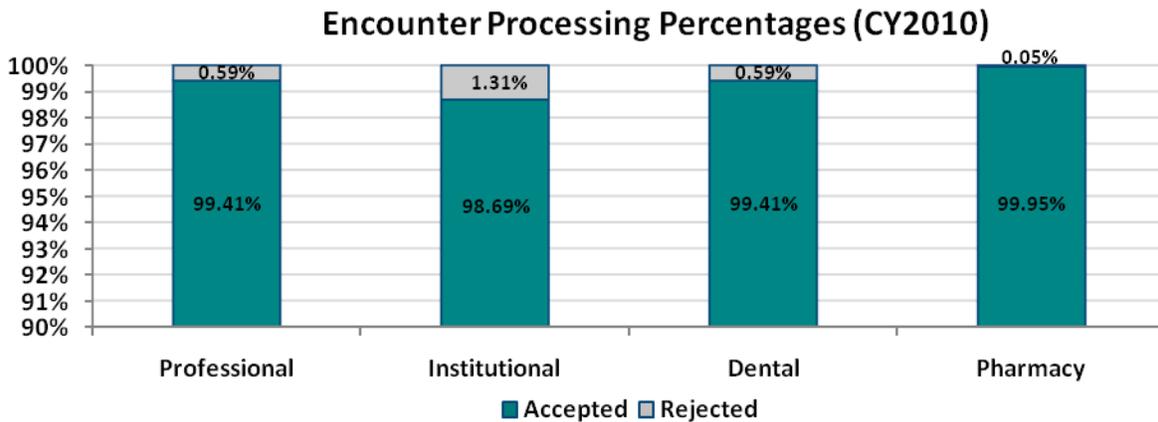


10.



### Question 10 – Encounters

Mercy Care Plan’s (MCP) proprietary Encounter Management System (EMS) provides for the accurate, timely and complete submission of encounter data –including all billed, paid and denied units and charges, as well as the National Provider Identifier (NPI) – to AHCCCS in HIPAA compliant 837(I/P) format. Developed with the functionality to manage encounter data across the encounter submission continuum – including preparation, review, verification, certification, submission, and reporting – the system consolidates required claims data from multiple sources (e.g. QNXT™ and our Pharmacy Benefits Manager) for all services (including those in the prior period) for which MCP incurred a financial liability, as well as claims for services eligible for processing where no financial liability was incurred. Comprehensive, coordinated edits and workflow management tools, including those described below, then identify and address potential data issues at the earliest opportunity. Our collaboration with AHCCCS’ encounter processing unit contributed to the successful acceptance of over 99 percent of all submitted encounters in calendar year 2010, as shown in the table below.



### Completeness, Timeliness and Accuracy

**Claims Processing:** Our core claims and eligibility processing system, QNXT™, uses a series of active claim edits to determine whether select claim fields contain required values and denies, completely or in part, claims submitted with missing or invalid information. The provider must then resubmit the claim with complete, valid information to receive payment. To better support improved processing, completeness, and accuracy, MCP reconciles our member files with AHCCCS’ monthly 834 transaction and then resumes posting daily 834 transactions, reporting any discrepancies to AHCCCS’ Member File Integrity Services Unit.

**Encounter Staging Area:** Upon successful adjudication and payment within QNXT™, claims are exported to EMS’ encounter staging area, a quality control measure utilizing intermediate data tables wherein the receipt of all QNXT™ claims data is verified by way of a transfer validation report reconciling the paid claim counts in QNXT™ to those within EMS. Valid claims data is then loaded into EMS, while encounter management staff research, track, and report any discrepancies to resolution.

**EMS Scrub Edits:** Encounter management staff design and apply custom, AHCCCS-specific edit profiles to encounter data within EMS – aligning our internal encounter edit configuration with AHCCCS’ encounter edit configuration – thereby improving encounter acceptance rates, as data unlikely to pass AHCCCS edits are pended or rejected until the underlying issue can be identified and resolved.

**Encounter Tracking Reports:** Encounter management staff utilizes a suite of encounter management reports to monitor, identify, track, and resolve issues concerning encounter data at any point in the submission process. These reports, in allowing us to monitor the status of each encounter within EMS by, for example, claim adjudication date and date of service, provide for the accurate, timely and complete submission of encounter data to AHCCCS, as required, ensuring that encounter data arrives no later than 200 days after the end of the month in which the service was rendered or the effective date of enrollment with MCP, whichever is later, and pharmacy related encounter data no later than 30 calendar days after the end of the quarter in which the pharmaceutical item was dispensed.

**Encounter Aging Reports:** These reports, in providing the aging and status of any encounter in process, allow encounter management staff to prioritize their efforts, further supporting the accurate, timely, and complete submission of encounter data.

**Review & Verification:** As part of our continuous process improvement activities and compliance procedures, MCP periodically conducts chart audits, comparing providers' medical records to claims data in order to verify that there are no discrepancies between the service codes, number of units, and diagnosis codes documented in the medical record and the claims data. MCP cooperates with AHCCCS' annual encounter validation studies by coordinating the collection of member medical records from providers for AHCCCS.

**Certification:** MCP includes, with any encounter submission, a signed certification attesting that the services listed were actually rendered [42 CFR 455.1(a)(2)]. Encounters are submitted to AHCCCS, in the format prescribed by AHCCCS.

**Submission:** HIPAA-compliant encounter files are created according to AHCCCS' submission requirements and schedule.

**Encounter Error and Acceptance Reports:** Generated upon receipt of AHCCCS' response files (277, 277U, NCPDP), these include the age and description of submission errors and provide the information necessary for encounter management staff to promptly identify, track and resolve encounter errors. Should a claim require re-adjudication as the result of an encounter error, it is resubmitted to QNXT™ for processing, and an adjusted claim imported to the EMS for resubmission to AHCCCS in accordance with encounter correction protocol. EMS then generates, as required, the appropriate void, replacement and/or corrected records. If re-adjudication is unnecessary, the encounter management unit will perform the corrections necessary to allow resubmission of the associated encounter per protocol.

**Reporting:** MCP's reporting process complies with AHCCCS' requirements regarding reports, report content and frequency of submission, with Policies and Procedures (P&Ps) providing for AHCCCS' receipt of any deliverable (e.g. "Corrected Pended Encounter Data", "New Day Encounters", Medical Records for Data Validation") by 5:00 PM on or before the due date indicated or, should the due date fall on a weekend, State mandatory furlough day, or a State Holiday, 5:00 PM the next business day.

**Reinsurance Eligibility/Aging Reports:** To maximize utilization of AHCCCS' reinsurance program, MCP's Finance Department manages a separate, though closely coordinated process, wherein dedicated reinsurance staff runs a monthly query against QNXT™ to identify, given predetermined thresholds, claims eligible for reinsurance. These claims are then compared to EMS to isolate pended or denied encounters less than three months from the respective Prepaid Medicaid Management Information System (PMMIS) adjudication deadline, allowing reinsurance staff to prioritize and work them accordingly. Encounters for any claims recouped in full are voided, with replacement encounters submitted in the case of any recoupment/adjustment resulting in reduced/increased claim value. Training and P&Ps address the specific nuances associated with the four types of reinsurance cases.

## **Remediation Strategies**

MCP's Health Plan Operations (HPO) team, under the direction of VP of HPO and supported by two encounter specialists who research each pend or denial edit from AHCCCS. The team employs diverse strategies to track related issues to their point of origin; utilizing continuous improvement methodologies (e.g. PDSA) to identify – through root cause analysis – assess, remediate, and control sources of error:

**Manual Adjudication:** Standard operating procedures employ aggressive measures for addressing claims analyst error with regard to procedural, payment, or financial accuracy. These include documented coaching, Performance Improvement Plans and, if need be, further corrective action up to termination. In the instance a manual adjudication error is traced to a claims procedure, a Claims Training Update (CTU) is distributed to claims analysts to prevent further errors and procedures and training materials are updated as necessary.

**Auto Adjudication:** The HPO team reviews all encounter edits, pends, and denials in relation to the QNXT™ system set-up for member enrollment, benefits, edits, provider set-up, and reference files to validate correct application to all submitted claims processing in QNXT™. Impacted claims in process are pended and adjusted if need be, and manual workarounds adopted as necessary in QNXT™ until the issue is resolved.

**Provider Education:** HPO identifies opportunities for targeted provider education with regard to specific errors related to unacceptable claim and billing practices. Based upon the specific errors identified, HPO works with provider services personnel to complete outreach, education, and training to providers. HPO and provider services concentrate on reducing the frequency of providers that have a history of submitting incomplete, inaccurate, or untimely claims for additional training and support.

**Encounter Workgroup:** HPO leads a cross-functional group comprised of system configuration specialists, Provider Claim Educator, and personnel from: 1) IT; 2) claims; 3) compliance; 4) encounters; 5) provider data management; and 6)



provider services. This workgroup meets weekly to address any issues with resolving pends, denials, improve workflows, and address any open encounter system issues.

**Collaboration:** MCP personnel attend a monthly meeting wherein encounter management, claims, compliance, finance, and HPO personnel collaborate with AHCCCS' staff on resolving pended encounter issues.

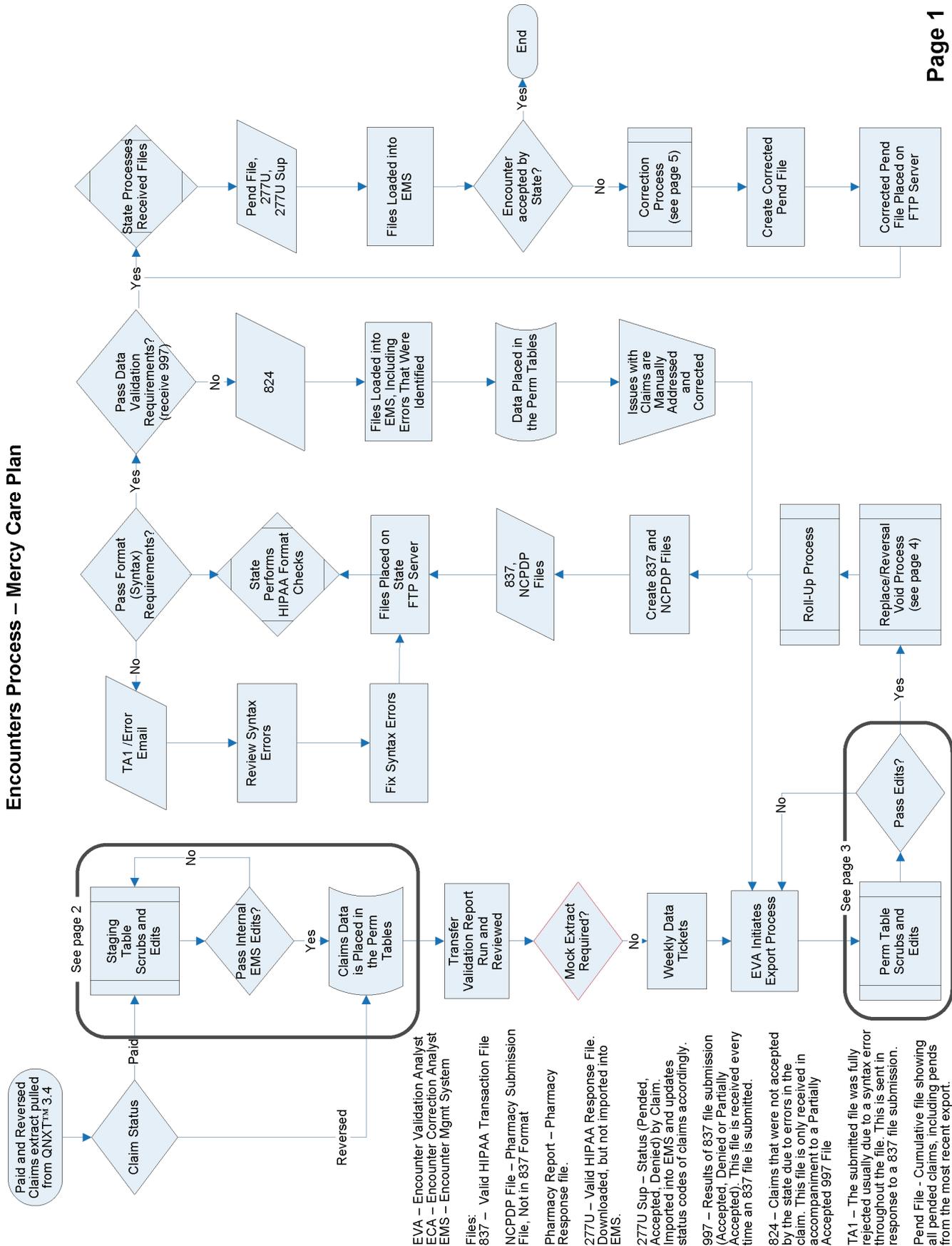
Examples of the HPO team's success in this regard include:

- Recognizing that the manual input and maintenance of provider data poses an unnecessary risk to the accuracy of provider information, MCP implemented an automated front-end process, downloading provider reference files from AHCCCS every two weeks, then editing against them to mitigate associated downstream errors.
- When the improper configuration of edits related to "age" and "maximum units available" was identified as a source of error, the edits were reconfigured, and the process by which they are maintained was modified to utilize AHCCCS reference files.

The HPO team monitors all claim audit findings and Claim Dashboard results, approve, and validate all system changes (e.g. reference file updates, fee schedule updates and benefit changes). This team is also responsible for post-production validation of all claim processing related projects and system change activities.

Flowcharts illustrating MCP's encounter submissions process can be found on the following pages.

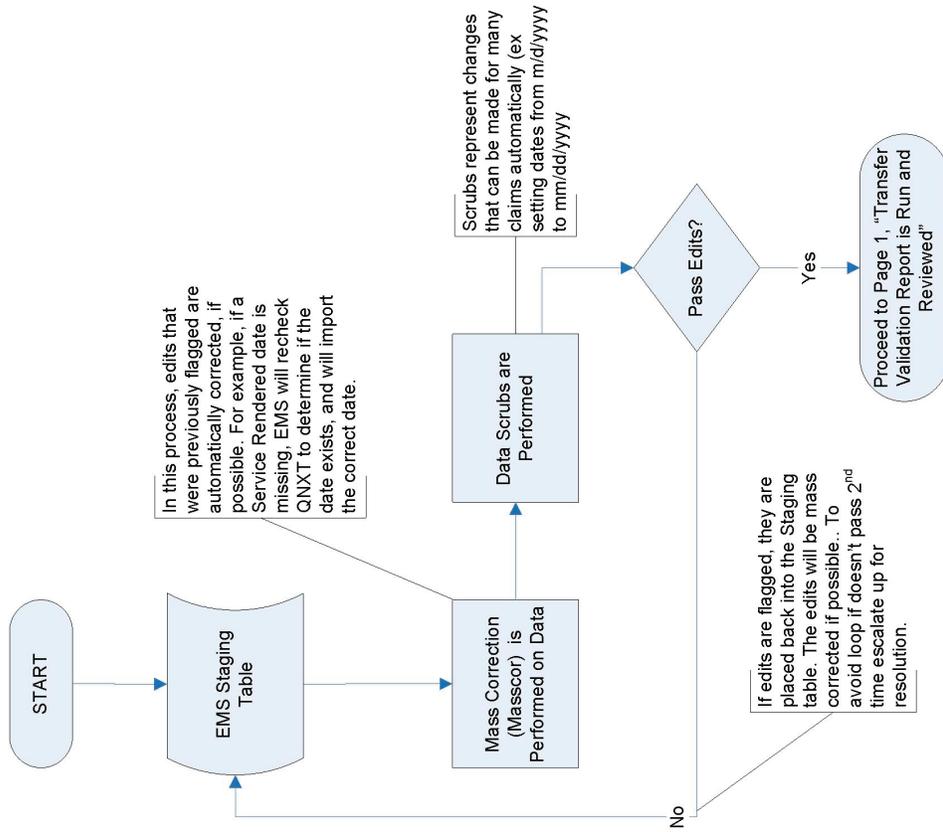
# Encounters Process – Mercy Care Plan



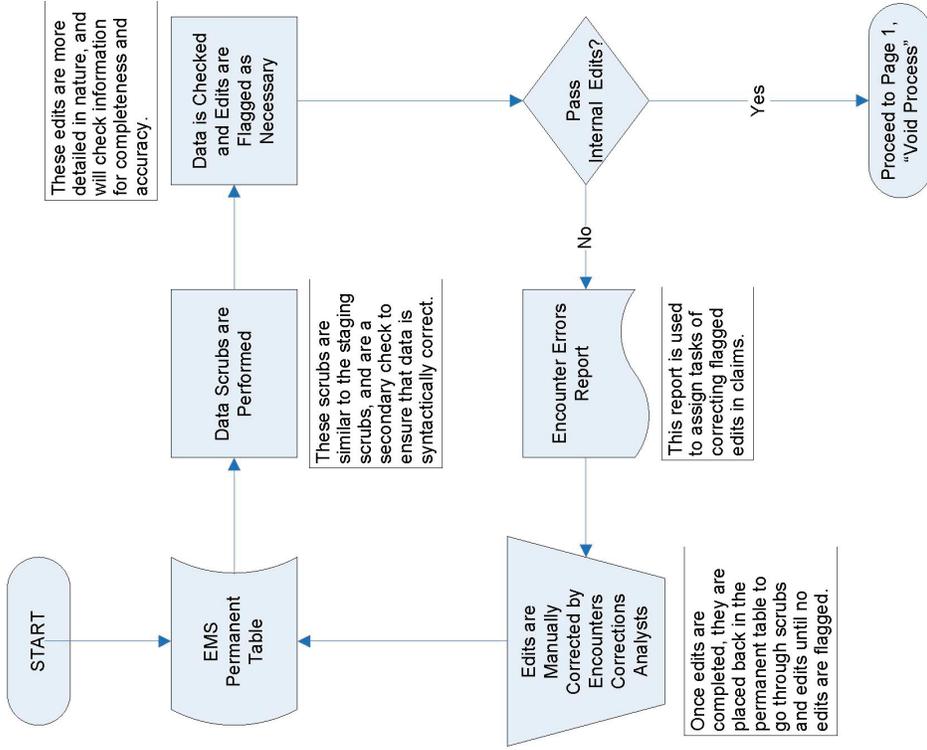
EVA – Encounter Validation Analyst  
 ECA – Encounter Correction Analyst  
 EMS – Encounter Mgmt System

Files:  
 837 – Valid HIPAA Transaction File  
 NCPDP File – Pharmacy Submission File, Not in 837 Format  
 Pharmacy Report – Pharmacy Response file.  
 277U – Valid HIPAA Response File. Downloaded, but not imported into EMS.  
 277U Sup – Status (Pending, Accepted, Denied) by Claim. Imported into EMS and updates status codes of claims accordingly.  
 997 – Results of 837 file submission (Accepted, Denied or Partially Accepted). This file is received every time an 837 file is submitted.  
 824 – Claims that were not accepted by the state due to errors in the claim. This file is only received in accompaniment to a Partially Accepted 997 File  
 TA1 – The submitted file was fully rejected usually due to a syntax error throughout the file. This is sent in response to a 837 file submission.  
 Pend File - Cumulative file showing all pending claims, including pends from the most recent export.

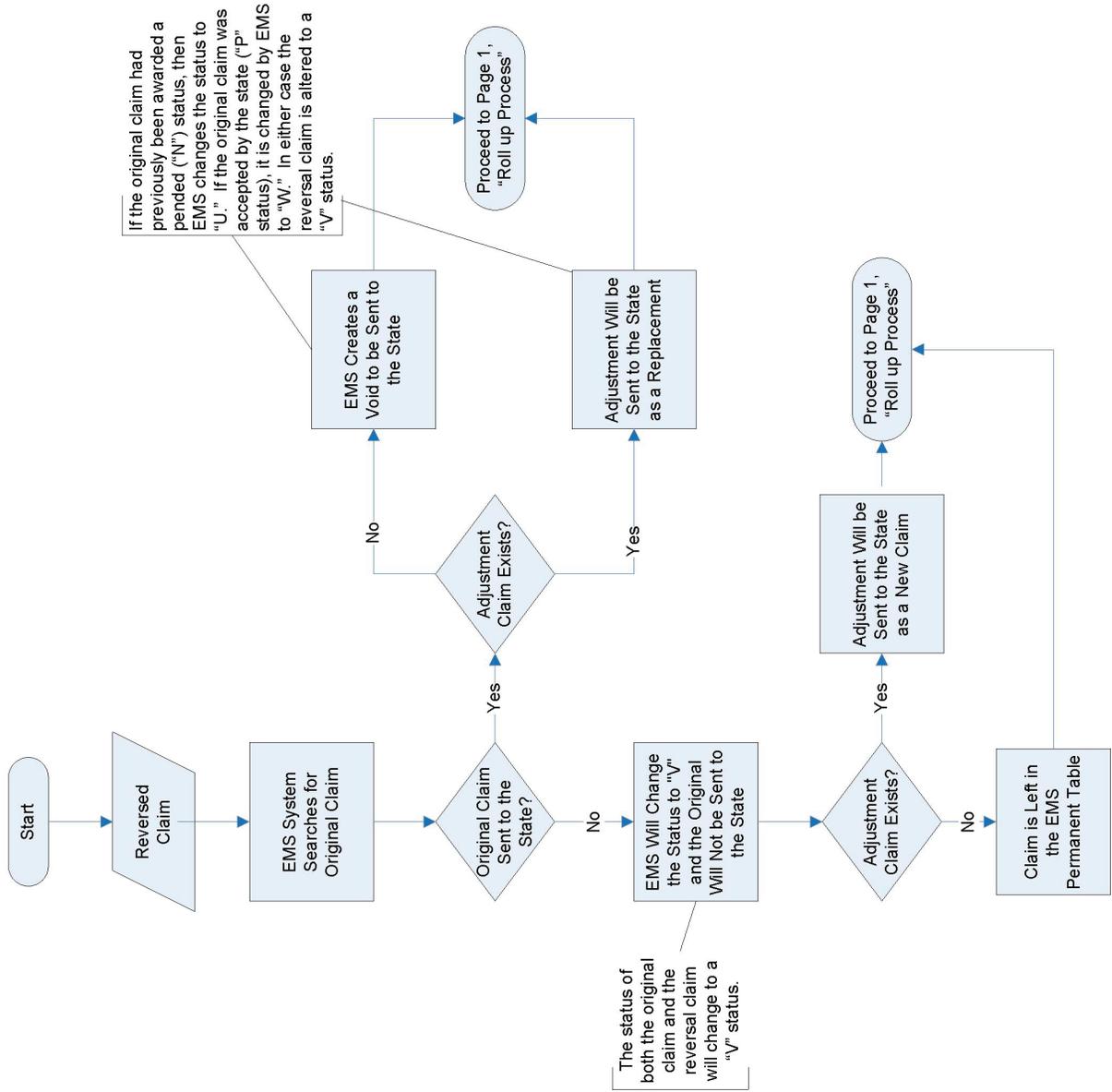
## Staging Table Scrubs and Edits Process



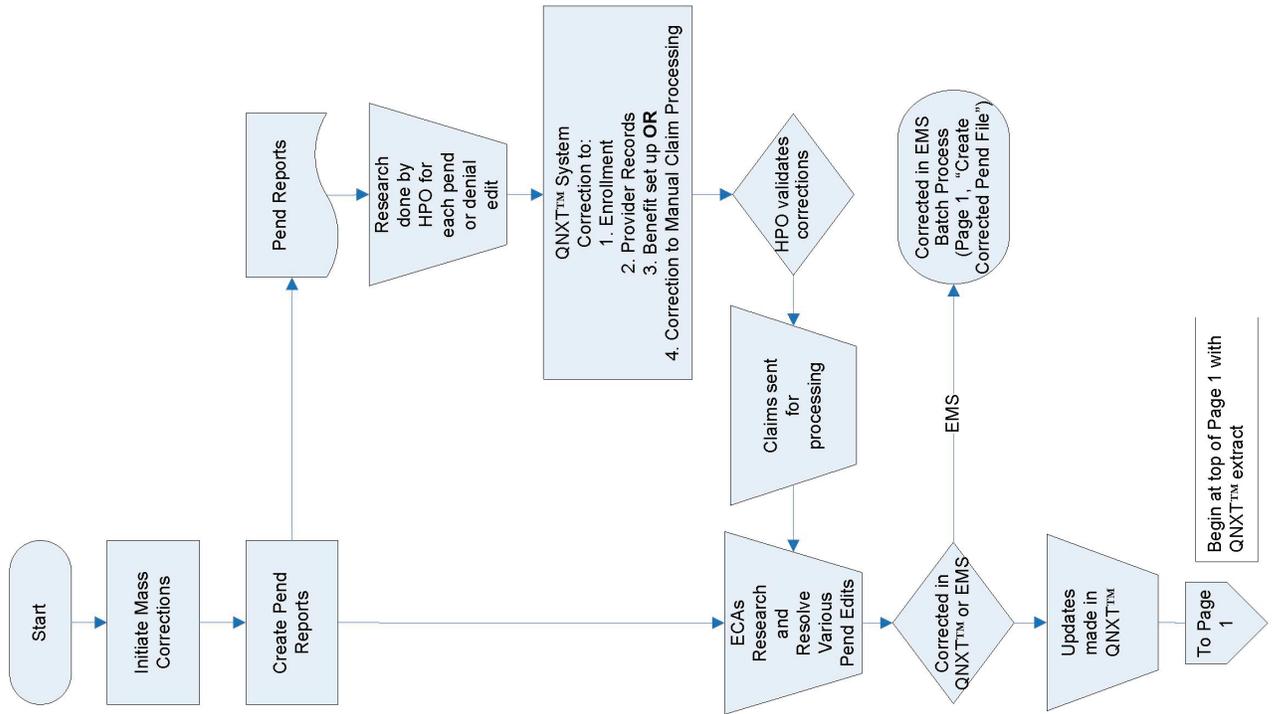
## Permanent Table Scrubs and Edits Process



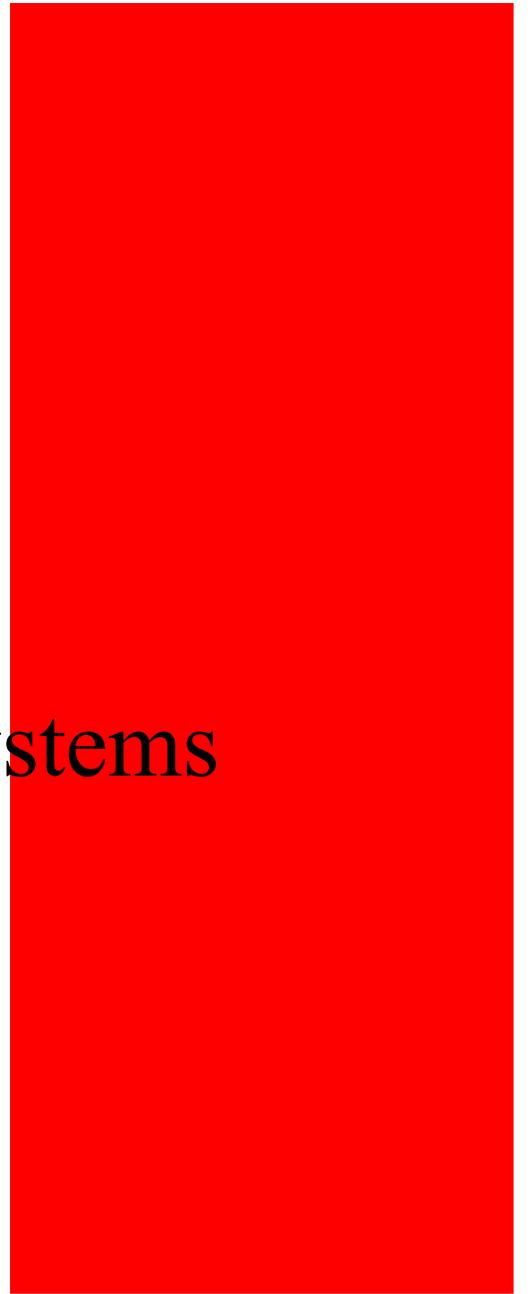
## Reversal/Replace (Void Process)



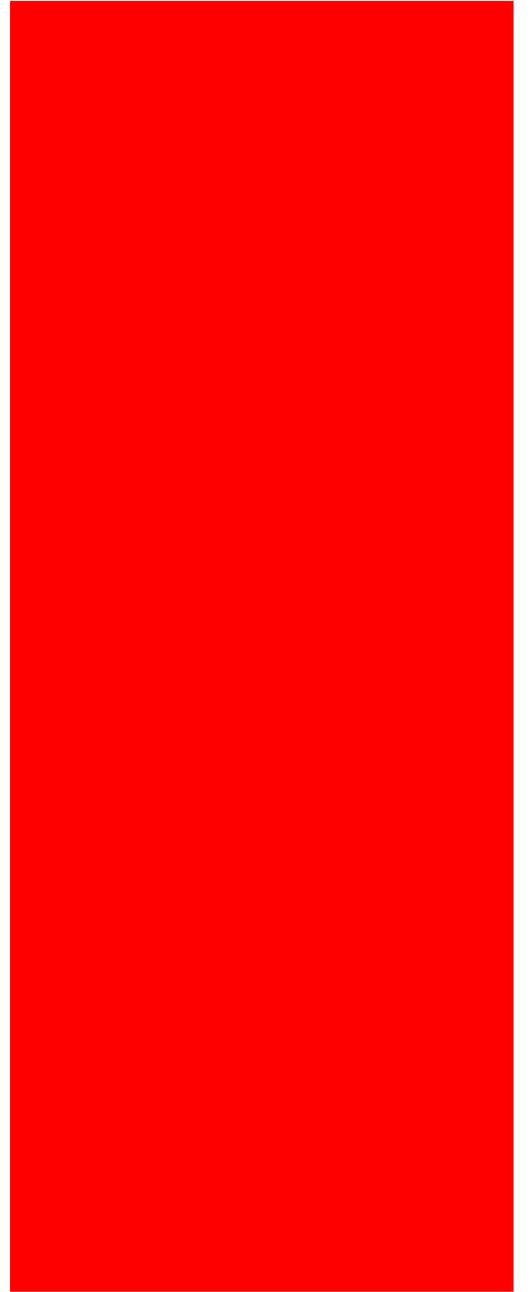
# Correction Process



# Information Systems



11.



## **Question 11 – Information Services**

Mercy Care Plan (MCP), through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, has over 10 years' experience supporting the ALTCS line of business. Today, our information system collects, stores, integrates, analyzes, validates, and reports data on over 8,800 ALTCS members, assimilating the member and provider information, case management, service provision, claims and reimbursement data necessary to support the associated financial, medical and operational management. Our Information Technology (IT) team, led by a Vice President of Technology Support with over 15 years' experience, includes 66 experienced, Phoenix-based FTEs. Together, they coordinate and perform key functions, including system architecture and operations design, application development, software engineering, quality assurance and Electronic Data Interchange (EDI) support, necessary to support over one million Medicaid members across health plans spanning 10 states.

IT staff work closely with MCP's Health Plan Operations Department (HPO), a team of performance improvement specialists dedicated to providing for the optimal alignment of MCP operations with ALTCS' objectives. Led by our Vice President (VP) of Health Plan Operations, HPO works closely with AHCCCS representatives, health plan leadership, IT staff and other stakeholders to continuously improve the quality and responsiveness of health plan services for members and providers alike. The department monitors and evaluates the cross-functional flow of data between case, quality, utilization management, provider, and member services departments to identify and implement improvements supporting timely access to the accurate information necessary to address the unique needs of ALTCS members. One of the department's primary goals is to identify and operationalize opportunities whereby data/information can strengthen and improve the relationship between CMS, members, and Primary Care Providers (PCPs). This includes assisting in the evaluation of new technologies and new uses of existing technology.

IT management works with HPO staff to develop and maintain written policies, procedures, and job descriptions necessary to "lock in" system and operational improvements. Annual reviews then verify policy and procedures' (P&Ps) continued agreement with current practices. If MCP leadership ever desires to move any Arizona-based IT function(s) outside the State of Arizona, we will first obtain AHCCCS' approval, submitting a request to the Division of Health Care Management, no fewer than 60 days prior to the proposed change, detailing the proposed change(s) and the processes providing for their efficient and effective implementation.

Schaller has engaged KPMG since 2000 to perform SAS 70 audits, including Operating Effectiveness for Claims Processing Controls and Related General Computer Controls. All audit reports have reflected unbiased opinions.

### **Technical Interfaces**

The design goal for MCP's information system is to use powerful, reliable, and expandable data processing systems. The foundation of this platform is a redundant, high speed Local Area Network (LAN) and Wide Area Network (WAN) and clusters of servers with built-in redundancy. This approach provided 100 percent uptime for all core business systems in 2010. Schaller's network infrastructure consists entirely of Cisco routers, switches, and firewalls. Cisco standardization provides maximum latitude in equipment configurations. Cisco routers support our MPLS network, external traffic to the Internet, and connections to other private networks. Core business applications run on a cluster of Hewlett Packard ProLiant DL 380/580 servers. Each server is equipped with a minimum of two dual-core Intel processors and 4GB of RAM. Applications loaded on the server pool access data from high-end database servers. These 64-bit, Itanium class database servers attach to EMC and HP storage arrays via Brocade switches. This server configuration provides all necessary computing power, redundancy and is scalable to meet both enrollment growth and an increase in requirements. MCP is able to add servers to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally. This scalability allows systems to match any escalation in demand associated with AHCCCS'/MCP's performance requirements, while at the same time maintaining system uptime and performance. Network traffic and users accesses to the core application are load balanced by f5 Global Load Balancing services. MCP's member services call center runs on a Schaller supplied Avaya S8500 IP switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts.

The information systems designed and implemented over the course of Schaller's' 20 year relationship with AHCCCS reflect the specific needs of Arizona's medically vulnerable populations, with each component contributing its part towards the achievement of ALTCS' Guiding Principles.

Schaller's information system currently supports AHCCCS' required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) as well as the procedures, policies, rules and statutes in effect during the term of our contract. Each data transmission is accompanied by MCP's assigned

security code, thereby enhancing data security, and system processes provide for the immediate identification of any data inconsistencies, allowing for their prompt resolution.

## **Hardware**

When Schaller designed the information systems for MCP and its affiliates, the goal was to use powerful, reliable and expandable data processing systems to serve the needs of MCP and its affiliates' members now and far into the future. High speed LAN and WAN, in addition to clusters of servers, provide the foundation for our information system, and multiple levels of redundancy support uninterrupted access. Should one server node go down, others temporarily assume its processing burden such that the event is virtually imperceptible to the end user. In fact, this methodology provided 99.99 percent uptime for all core business systems in 2010.

In addition, servers can be added to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally – all without ever bringing the applications down. Such scalability will allow our systems to match any escalation in demand associated with AHCCCS's performance requirements while at the same time maintaining system uptime and performance.

### ***Data Communications Hardware***

Schaller's network infrastructure consists entirely of Cisco routers, switches and firewalls, providing 99.99 percent uptime on the network for 2010. Standardizing on Cisco has provided maximum latitude in equipment configurations. Cisco was chosen because it provides the most reliable hardware in the industry, with worldwide 'follow-the-sun' technical support. Cisco routers support the MPLS network, external traffic to the Internet, and connections to other private networks.

### ***Application Server Hardware***

Schaller's core business applications run on a cluster of Hewlett Packard ProLiant DL 380/580 BL 460 servers. Each server is equipped with a minimum of two dual-core Intel processors and 4GB of RAM. All of the systems of Schaller's Medicaid affiliates that run on this cluster achieved 99.99 percent or better uptime in 2010. These servers utilize f5 Global Load Balancing services for load balancing network traffic and for user access to the core business applications. Applications loaded on this server pool access data from high-end database servers. These 64-bit, Itanium class servers attach to EMC, Hitachi HDS and HP EVA storage arrays via Brocade switches. This server configuration provides all necessary computing power, redundancy and can be scaled dynamically to meet growing requirements.

### ***Telecommunications Hardware***

Schaller chose the industry leading systems from Avaya to build an enterprise level telecommunications system. The corporate office runs an Avaya Communications Manager Platform, which maintains extra capacity to cover any unforeseen spikes and growth spurts, handling up to 375,000 calls in an hour if necessary. This server is one part of a cluster of Avaya PBXs that provide virtually unlimited growth potential. Data can be shared between servers through distributed IP support, allowing real-time backup of data to the hot-site and dynamic distribution of calls if needed. They are managed 24 hours a day by Aetna telecommunications staff with multiple levels of redundancy to maintain uptime. In fact, it would take four separate points of failure throughout the nation to bring the system down, and even an agent could securely configure the PBX to allow a WAH strategy, allowing phone connectivity remotely. This provides members and providers with a virtually fail-safe means to reach MCP whenever necessary.

## **Software**

**QNXT™** - At the core of Schaller's application architecture is QNXT™, a rules-based information processing system comprising 28 integrated modules that maintain the following:

- Claims data, including associated adjudication, COB and TPL processes
- Demographic, eligibility and enrollment data, including prior coverage
- Provider contract configuration, including network and services
- EDI processes
- QM/UM including, but not limited to Prior Authorizations and concurrent reviews

QNXT™ leverages Microsoft's .NET architecture, providing for flexible, scalable, and seamless systems integration. In addition, the system's foundational database is Microsoft's SQL Server, permitting a wide variety of applications to analyze the data, display results, and print standardized and customized reports.

The cornerstone of Schaller's claims adjudication process, QNXT™ accepts – via the supporting technical interfaces – AHCCCS' Daily Enrollment and Manual Payment Transaction files', and then updates our member records accordingly. Automated processes reconcile QNXT™'s resident member files with AHCCCS' monthly update recording the results for

AHCCCS' review should it be necessary. MCP's enrollment team then validates the data for accuracy, auditing relevant files and reviewing any resultant fallout reports. Should the process bring any errors to light, enrollment personnel promptly notify AHCCCS' Information Services Division and work the issue to resolution. Enrollment staff then resume posting of daily updates, beginning with the last two days of the month.

QNXT™ uses weekly downloads of provider data from AHCCCS' secure FTP server to update MCP's provider files. Enrollment staff then use unassigned enrollment reports to verify each member's assignment to an individual PCP, our PCP assignment file is as current and complete as possible. System queries identify new enrollments and generate welcome letters accordingly. These are added to new member welcome packets, which are delivered by members' assigned Case Manager (CM). Updated date-sensitive PCP assignment information is available to AHCCCS in electronic format upon request.

QNXT™ supports automation of routing processes, thus introducing improved efficiencies and accuracy to the adjudication process. For example, three-tier logic matches claims and authorizations based on criteria such as member, provider, service code, and dates of service. The system automatically deducts claimed services from authorized units, thus reducing the need for manual affiliation by claims analysts.

Several applications compliment QNXT™'s claims processing functionality. The first, **iHealth**, enforces select payment policies from one of the industry's most comprehensive correct coding and medical policy content libraries. The second, McKesson's **ClaimCheck**®, expands upon those capabilities by allowing claims leadership to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power. Finally, Medical Data Express' (MDE) **Outpatient Facility Services Pricer** supports the pricing and correction of outpatient hospital claims.

As the steward of our members' demographic, capitation, PCP, and eligibility and enrollment data, QNXT™ serves as the primary source of data for multiple applications, including CaseTrakker™, our principal member and medical management application, VisionPro and EMS. Our systems data flow, provided at the end of this section, illustrates how the exchange of data between these systems, and throughout our organization, addresses the needs of our ALTCS members.

**CaseTrakker™** – MCP's primary case management application, CaseTrakker™ supports case management (CM) activities including but not limited to case management assignment, assessment, care planning, service coordination and document management. We take advantage of the application's ability to enforce preconfigured workflow rules to prompt predefined event-driven actions, thereby supporting compliance with associated standards. The application uses branched logic to display context sensitive information, such as assessment deadlines, service coordination notes and service accessibility data, thereby supporting more effective case management. Upon login, a summary screen presents CMs with a color-coded overview of their assigned caseload, assessment due dates and associated tasks. An automated escalation process alerts CMs and supervisors of upcoming and overdue assessments, and audit reports support case management staff's compliance with ALTCS standards. MCP leverages CaseTrakker™'s capabilities to expedite and/or automate many Long Term Care (LTC) processes including, but not limited to, the following:

**Client Assessment and Tracking System (CATS) Data Transfer:** Automated processes provide for the electronic submission of complete, correct and timely (within 14 days) data related to CM changes, assessment completion dates, behavioral health code changes, placement history and cost effectiveness studies to the AHCCCS CATS.

**Case Management Reporting:** CaseTrakker™'s relational database structure and flexible report design capabilities support creation of unique reports promoting continued compliance with ALTCS standards. MCP's LTC Department maintains a suite of over 80 reports within CaseTrakker™ for ready access by LTC staff. Examples include case weight, placement, service authorization, assessment, and Cost Effectiveness Study (CES) compliance data. The application's ease of use permits authorized users to create their ad hoc reports as well.

**Performance Improvement Project (PIP) Support:** CaseTrakker™ supports MCP's QM Program through the production of reports addressing our strategies for continued performance improvement, providing for the ongoing measurement of our efforts to achieve significant, sustained improvement in the areas of clinical and non-clinical care. Automated reports regularly compare quality of care standards to claims data to identify any related trends within our service delivery system or provider network, allowing us to implement systemic interventions for quality improvement. This information is also shared with the State using approved formats. Examples of performance initiatives supported by CaseTrakker™ include Influenza Vaccinations, Diabetes measures (HbA1c, Lipids, Retinal Eye Exam) and Initiation of HCBS Initiation of Services within 30 calendar days.



**VisionPro** – A credentialing application, VisionPro houses provider data, including demographics, licensure, board certifications, sanctions, privileges and malpractice information.

**Encounter Management System** – EMS, a proprietary Schaller system, warehouses claims data, formats encounter data to AHCCCS requirements and processes CMS1500, UB04 (or UB92), dental, and pharmacy claims. Current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II) are kept on file as well. The system uses State provider and medical coding information – in conjunction with claims data culled from QNXT™’s data tables – to produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounters and encounter revisions. Health Plan Operations personnel, in conjunction with provider relations personnel, support AHCCCS encounter validation studies by submitting requested data within 90 days.

**Predictive Modeling** – Schaller’s predictive modeling tool assimilates information from a variety of sources, including the Actuarial Services Data Base (ASDB) described below, and transforms it into a series of markers measuring both risk and opportunity. It then scores these markers and assigns a rank to every member, reflecting both the level of risk and potential opportunity for improvement, thereby helping CMs provide the appropriate level of care coordination. In addition to its risk algorithms, the application identifies members who meet specific rules-based criteria for individual treatment interventions.

**ActiveHealth Care Engine** – MCP maintains an advantage in the integrated care coordination of our ALTCS members as a result of our affiliate ActiveHealth’s CareEngine® System – a claims-based clinical support system combined with an automatic message generator called Care Considerations. The system integrates medical and pharmacy claims data and lab results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms developed by ActiveHealth’s team of board certified physicians and pharmacists. It then identifies member-specific opportunities to optimize care and communicates evidence-based treatment recommendations – “Care Considerations” – to providers. At the same time, the system generates “Wellness Considerations” for members: communiqués focusing on prevention and wellness issues such as childhood immunizations, breast cancer screening, and disease appropriate screening and vaccinations.

**Grievance and Appeals Database** – Schaller maintains an internal, proprietary application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. This affords us the means to address not only issues affecting individual member and provider satisfaction, but potential trends in the delivery system as a whole, permitting health plan staff to take prompt, corrective steps to minimizing risks to performance standards.

**Alchemy** – Schaller’s document management solution, Alchemy supports the capture, management, and archiving of scanned documents, such as paper claims, and other electronic image files through their entire lifecycle, providing enhanced security, improved access and greater indexing flexibility.

**www.mercycareplan.com** – Schaller maintains a public website for MCP that complies with all requirements stipulated in ACOM’s Member (404) and Provider (416) Information Policies, with separate web pages providing static information tailored to ALTCS members’ and providers’ respective needs. Members and providers wishing to take advantage of MCP’s secure web capabilities are provided a link to the MercyOneSource web portal, described below.

**MercyOneSource** – MercyOneSource is a secure HIPAA-compliant web portal for MCP’s members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status, review benefits and prior authorization status, and send secure emails to MCP’s member services staff. Providers are afforded additional functionalities, including:

- Member eligibility verification
- Panel roster review
- Searchable provider list
- Claim status search
- Remittance advice search
- Submit authorizations
- Search authorizations

*MercyOneSource’s web-based Gap and NPS Logs support continued compliance with provider network requirements.*

We configure the portal to provide HEDIS® scorecard data, as well as alerts indicating when a member is due or past due for a HEDIS® -related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This

information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).

MercyOneSource has been instrumental in MCP's compliance with *Ball v Betlach*, as it affords providers secure, ready access to an online version of the AHCCCS Gap Log, wherein they can securely, discretely report gaps in critical services. The web portal avails providers access to an online version of the Non-Provision of Services (NPS) Log as well, providing for the prompt reporting of non-provision of critical services. Provider relations representatives work with providers, contributing education, training and outreach as necessary to support their use of the tool. An NPS/Gap Analyst in our LTC Department uses associated reporting capabilities to not only monitor providers' compliance, supporting the timely resolution of any reported gaps in service, but to replicate ALTCS' Non-Provision of Services Log accordingly.

Policies and Procedures (P&Ps) dictate that our website and portal comply with applicable provisions of the Americans with Disabilities Act, as well as ACOM's policy (405) concerning cultural competency. In addition, any information included therein that is not specifically identified by ACOM policy, but directly related to members or potential members, is first submitted to the Division of Health Care Management for prior approval. We submit, by November 15th of each year, an Annual Website Certification form (ACOM 404, Attachment B) verifying that all required information is current and available.

**Epocrates®** – Epocrates® provides a web-based online drug formulary reference to our providers that they can use at the time of treatment and prescription. The tool assists providers in reducing medication errors through the provision of up-to-date references that prevent or reduce errors by supporting accurate drug dosing or/and alerting them of potential drug interaction errors. It also delivers clinical alerts from the Federal Drug Administration and Centers for Disease Control.

**ASDB** – Schaller's Actuarial Services Data Base (ASDB) supports MCP's reporting and analytical capabilities, such as our multidimensional predictive modeling and statistical outlier analysis. The application houses eligibility, provider, prior authorization and claims data and serves as a key data source for a diverse user base, including Medical Management, Finance and Operations.

Analysts can use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports, drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that affords MCP's Medical Management staff access to member and provider profiles, as well as current cost and utilization trends. This gives MCP the ability to disseminate analysis results on treatment best practices to providers, who can then identify and prevent unnecessary migrations to higher levels of care and the development of chronic health conditions.

MCP reporting analysts cull data from ASDB, QNXT™ and CaseTrakker™ as necessary to satisfy the chart of deliverables provided in Attachment D of the RFP, supporting compliance with stated timeliness, accuracy and completeness standards. We maintain strict P&Ps providing for the review of all deliverable prior to submission to AHCCCS. However, if MCP falls out of compliance with any standard on a deliverable, or AHCCCS expresses concern during a reporting quarter, we will immediately begin to submit the impacted deliverable on a monthly basis until three consecutive months of compliance are achieved. We honor AHCCCS timeliness standards regarding requests for information, providing the requested information no later than 30 days after receipt of the request unless otherwise specified in the request itself.

**E-Prescribing** – Schaller, under the direction of MCP, is actively collaborating with AHCCCS, the Arizona Partnership for Implementing Patient Safety, providers, pharmacists, and other stakeholders on implementation of the State's EAzRx initiative. Schaller's president and CEO is a Designated Director on Arizona Health-e Connection's (AzHeC) Board of Directors, and it is AzHeC's EAzRx Steering Committee that is tasked with advancing the adoption and implementation of e-prescribing by Arizona providers. As a result, MCP is well attuned to EAzRx's goal to see nearly 100 percent of possible e-prescriptions e-prescribed by April 2013, as well as its supporting strategies. These include, but are not limited to:

- Educating providers as to available incentives, including CMS' 2011 Physician Quality Reporting System, 2011 Electronic Prescribing (eRx) Incentive Program, EHR Incentive Program (a.k.a. Meaningful Use), and their respective eligibility requirements
- Recognizing top e-prescribers in Arizona

- Encouraging patient involvement in the e-prescribing process

EHR adoption and e-prescribing discussions are routine components of MCP's provider education and outreach, and associated talking points are regularly updated to keep providers apprised of the State's progress and available resources.

### **Information Systems Monitoring**

Schaller's core business systems maintained a 99.99 percent uptime through the 2010 calendar year, due largely to the combined efforts of staff at our Network Operation Center (NOC), Operation Command Center and Production Services and System Platform Performance Departments. The four share one common goal: the optimization of our core business systems' performance. Our NOC and Operation Command Centers, for example, monitor systems performance 24/7/365 via state-of-the-art applications and tools, such as IBM Tivoli Monitoring (ITM) products. ITM is an event management/problem detection tool that can monitor Windows Server system attributes and System Event logs, as well as ASCII logs. It interfaces with other enterprise monitoring tools to provide a comprehensive yet consolidated view of problems across the enterprise. Production outages and system issues are managed by the Production Services Department which assembles and coordinates teams and vendors to facilitate quick resolution and provide escalation when needed. And finally, the System Platform Performance (SPP) Department provides enterprise-wide performance monitoring, tuning, trend analysis and reporting for large-scale and midrange systems/platforms and mainframe systems and applications in support of business operations. SPP aims to promote optimum throughput and efficient use of resources to meet established service level agreements and availability goals.

### **Disaster Recovery and Business Continuity**

Aetna's disaster backup and recovery strategy is to provide and maintain an internal disaster recovery capability. This strategy leverages the internal computer processing capacity of two state of the art, hardened computer centers located in both Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7/365 operation. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function as appropriate. The two data centers house Aetna's computer processing capabilities on three major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load balanced and supplemented by quick-ship and capacity-on-demand contracts, permitting each center to back the other up in the event of disaster. We maintain contracts with national vendors providing for replacement equipment and supplemental capacity as needed, further promoting compliance with recovery time objectives (RTO).

In the event of a data center disaster, the RTO to resume most production processing is four days from disaster declaration for all mainframe and mid-range systems and five days for LAN systems. Portfolios of highly available applications, such as web and pharmacy, have RTO's of six hours or less. These applications utilize mirroring and/or load balancing technologies between the datacenters to make certain that the reduced RTO's can be met. Aetna's voice and data network backbones are fully redundant using SONET ring technology and are recovered within 1 hour of a data center outage. In short, Aetna's data center recovery strategy and its application RTO's are consistent with or better than industry standards.

### **Data Backup**

Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data is cross vaulted between the two computer centers, with mainframe backups stored primarily on disk media and mid-range/LAN backups stored primarily on tape. Additionally, all mainframe disk data is mirrored to the alternate data center providing a simplified and timelier recovery for that piece of the environment. Any customer data lost as a result of a data center catastrophe will be recovered through re-submittals by service providers and/or recovery reconciliation teams.

### **Disaster Recovery Plans**

The Aetna Information Services (AIS) Executive IT Disaster Recovery Plan is the high level plan for recovery of a data center and its critical components. The plan is derived from over 50 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment which are needed to recover either data center. These plans are centrally maintained by our disaster recovery group, are stored both locally and offsite and are updated semi-annually or as needed by the respective infrastructure area.

Application recovery (DBAR) plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures. The plans are maintained routinely and utilize automated recovery processes to insure appropriate data resilience. These DBAR plans are validated annually with the application owners and business users with periodic integrated tabletop simulations.

Escalation and notification procedures are contained within disaster recovery plans to verify recovery team members, affected partners and business unit owners are activated in a timely manner. AIS's role during a disaster is to lead, manage, and staff the various recovery teams, which will also be augmented by additional vendor specialists under contract for certain supplemental recovery technologies, which AIS will coordinate.

### **Disaster Recovery Testing**

Aetna implements and maintains ongoing enhancements to disaster recovery plans and procedures. Testing is performed across a variety of applications and infrastructure components on a regular basis to promote ongoing disaster recovery readiness. Aetna routinely tests recovery elements of third party relationships including technology components, critical processes, and access points. These exercises can be initiated by either party and Aetna welcomes the opportunity to test these relationships as time and resources permit.

### **Business Continuity**

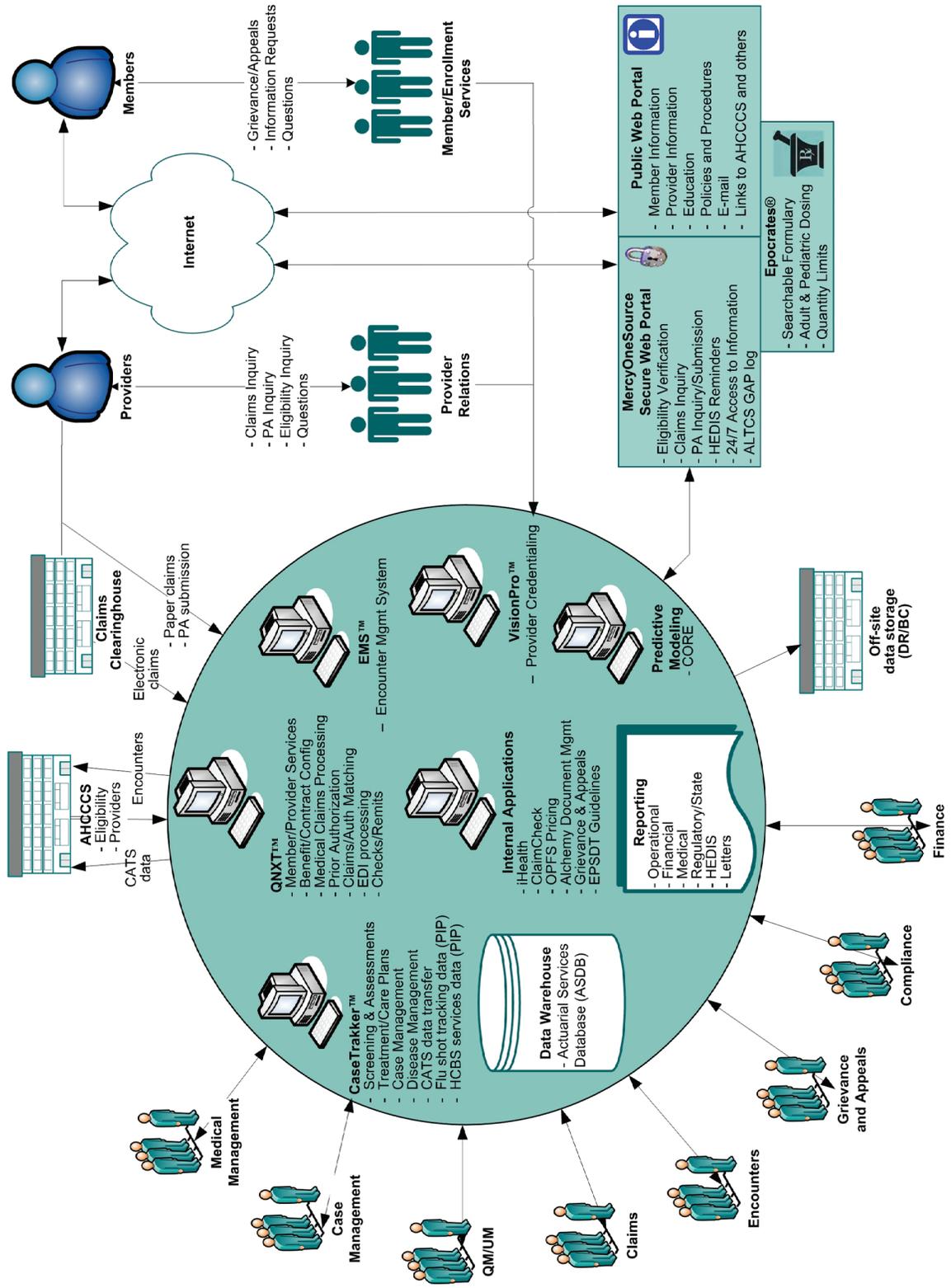
Aetna maintains and implements a detailed business continuity program, with over 300 plans to address its critical business work group operations. In the event of an office outage, processing is transferred to surviving offices within Aetna's network with little or no disruption to service levels. The detailed business continuity plans are maintained on a quarterly basis and in-depth tests are conducted periodically. Business Continuity Plans are also designed to mitigate the effects of an extended system outage and loss of third party business associates; they also address severe staffing shortages.

MCP's Business Continuity Planning and Recovery Coordinator is responsible for coordination of MCP's local DR/BC activities and works closely with Schaller to support continuity of business operations. The Business Continuity Planning and Recovery Coordinator's contact information is also on file with AHCCCS.

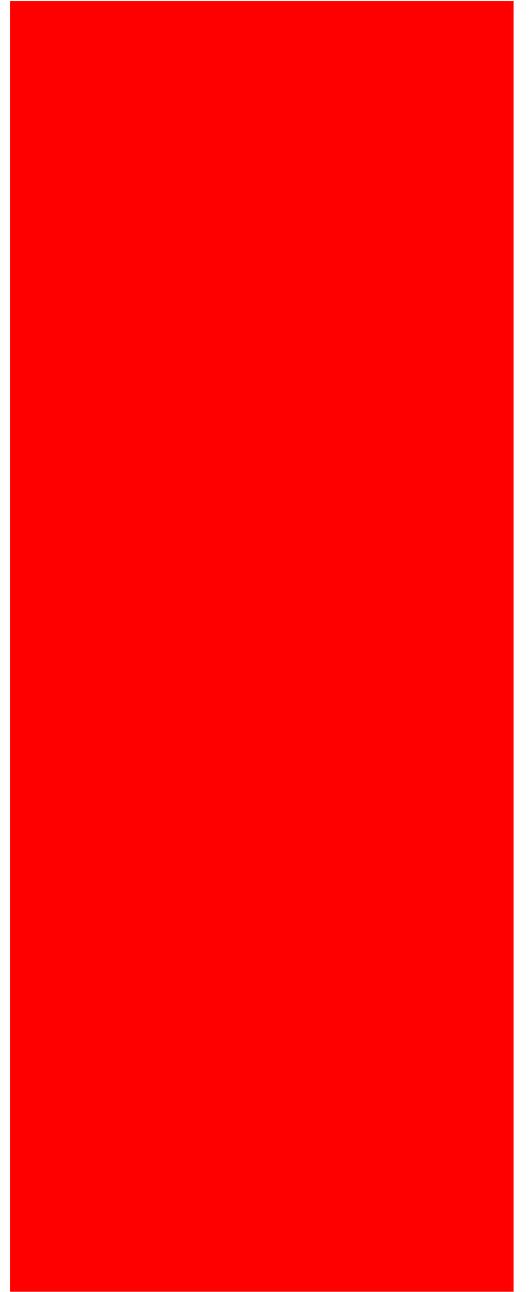
Schaller and MCP maintain a local version of the Disaster Recovery/Business Continuity Plan specific to their respective operations and local resources. The Plan contains a listing of key customer priorities, key factors that could cause disruption, and the timelines within which each anticipates resumption of critical customer services (e.g. providers' receipt of prior authorization approvals and denials), including the percentage of recovery at certain hours, as well as key activities required to meet those timelines. MCP's Business Continuity Planning Coordinator works in concert with our Training Department to see that both the Plan and our employee training program address the specific scenarios described in the ACOM (Section 104 – Business Continuity and Recovery Plan). MCP will submit a summary of our Business Continuity and Recovery Plan – in accordance with ACOM requirements – to the Division of Health Care Management 15 days after the start of the contract year and annually thereafter.

An illustration showing MCP's Application Data Flowchart can be found on the next page.

### Mercy Care Plan Application Data Flow



12.



## Question 12 – Information Services

Mercy Care Plan (MCP) is aware that effective and efficient change order management of our hardware and software resources is a critical administrative process. Our chief operating officer (COO) has authority and responsibility over our IT change order management. MCP, through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, has access to comprehensive IT tools and solutions. This subcontract provides MCP with access to an IT organization that has efficiently and effectively supported the ALTCS contract for over 10 years and today serves over one million Medicaid health plan members in 10 states. Schaller's IT organization is flexible and responsive, led by a Vice President of Technology Support with over 15 years' related experience. Schaller's IT organization provides experienced and trained Phoenix-based FTEs who are responsible for the hardware and software change order processes. Our COO manages the business continuity process and holds Schaller accountable for the Change Order Process (COP). Schaller's COP begins with communication and extends through comprehensive planning and coordinating of project tasks, scheduling for minimum disruption, and quality control change management. The Schaller process protects MCP's core business applications and the systems from changes that may be disruptive or have an unacceptable level of risk. Our COP manages hardware/software changes through an approach based on technical and business evaluations, prioritization, coordination, and optimum use of resources. Schaller uses Remedy Change Management system version 7.5 PS4 from BMC Software to manage system change requests.

As part of MCP's change order management process, we define a system change as any modification that impacts the shared network, computing environment, or business applications by altering its existing state. This includes, but is not limited to:

- System Hardware: Servers or server components, power conditioners, etc.
- System Software: Operating systems, antivirus, core business applications, etc.
- Databases: Microsoft SQL Server, Microsoft Access, etc.
- Network Hardware: Routers, switches, firewalls, VPN, security appliances, etc.
- Desktop Management: Hardware, operating systems, Citrix client, antivirus, etc.

MCP assigns system changes to one of three categories: (1) Full Cycle: by default all changes fall into this category. These changes are discussed and may be approved at the weekly IT COP meeting; (2) Expedited: change needs to occur prior to the next IT COP meeting. These changes require approval of MCP's COO or designee and a Schaller IT Director; and (3) Routine: a minor change (e.g. changing a web page document) using an accepted process.

MCP recognizes that other activities, deemed to be comparatively minor, low-risk tasks, are routinely performed in the interest of system security and stability. It is our experience that the likelihood of these activities having an impact on system stability is extremely rare, as they are not changes to a processing environment. Therefore, MCP leaves it to Schaller's IT management team to identify, track, manage and report on these activities. Examples of these administrative changes include, but are not limited to the following:

- Account administration (i.e., user profiles, password resets, user desktop application setup)
- Adding share points
- Restoring files (individual PC's)
- Changing backup tapes and job schedules
- File system adjustments
- Work management (output queues)
- Managing storage pools

MCP requires that Schaller mitigates the risk associated with any upgrade by: (1) releasing any upgrade in a secure Schaller "back office" environment to test its impact prior to promoting it to the "production" environment; (2) backing up the entire system prior to the upgrade so Schaller can reverse the process and return the system to its pre-upgrade state if necessary; (3) requiring the hardware/software vendor to have its staff to on-site to facilitate and monitor the COP; and (4) training MCP and Schaller employees/end users on the conversion/upgrade. Standard operating procedure mandates that Schaller provides MCP and AHCCCS with the following information prior to any system conversion or upgrade:

- System (hardware/software) to be upgraded and the nature of the upgrade
- Timeframe for the upgrade
- How PHI will be secured and protected during the upgrade

- How the upgrade will be tested prior to final promotion
- A plan to revert to the original system if there's a problem

Although there is a standard MCP/Schaller committee that reviews conversion/upgrade requests; it is the standard operating procedure that MCP and Schaller will form a COP team to manage a major conversion/upgrade. This team is led by MCP's COO or designee. Under MCP's leadership and direction, Schaller upgraded QNXT™ to version 3.4 in July 2010. By adhering to our COP tools, this upgrade was executed without a disruption to system availability and zero deficits. The MCP and Schaller team responsible for this successful upgrade fully documented the process. This documentation is a valuable resource for future system conversion/upgrades and will be a yardstick to guide future system conversion/upgrade activities. MCP anticipates an upgrade to QNXT™ version 4.8 during this contract period in order to accommodate pending ICD-10 requirements.

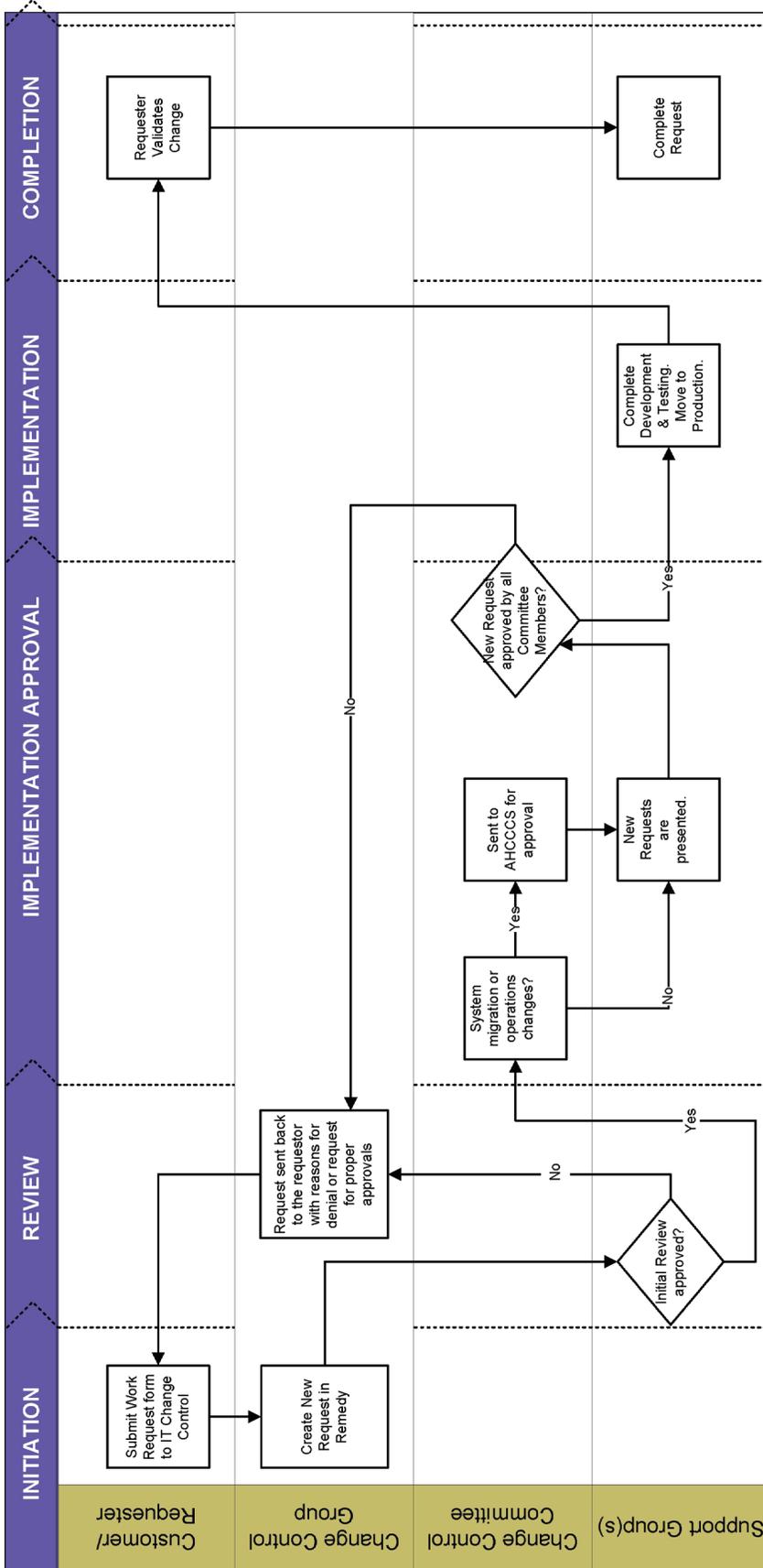
Schaller, on behalf of MCP, is evaluating, and expects to implement during this contract period, system conversions in four support systems. These conversions are described in the table below.

Existing System	Purpose	Replacement	Reason for Conversion
QNXT™, version 3.4	Rules-based information processing system to manage Medicaid member eligibility and claims data	QNXT™, version 4.8	Accommodating ICD-10 requirements and increase responsiveness to AHCCCS requirements
Encounter Management System (EMS)™	Process and submit encounters	Under review and assessment	Increase responsiveness to AHCCCS requirements
CaseTrakker Enterprise™	Case Management	CaseTrakker Dynamo™	Increase member/provider access to care plans
VisionPro™	Credentialing	Echo	Increase responsiveness to AHCCCS requirements
MercyOneSource	Provider web portal	Under review and assessment	Increase provider access to PA and claims data

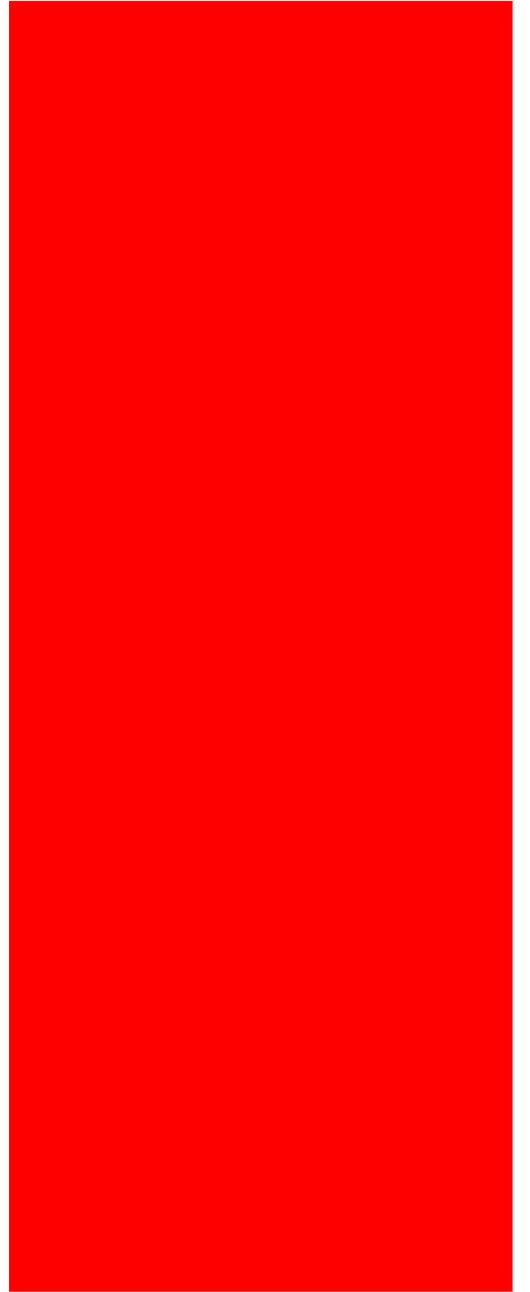
As in any instance of a major system conversion impacting claims processing or any other major business component, we will follow AHCCCS' approval and implementation procedures. This includes the submission – no less than six months prior to any anticipated implementation date – of a system change plan to AHCCCS for comment and review, including a timeline, milestones, go/no-go decision points, project oversight and an allowance for adequate testing prior to implementation. Similar to our most recent successful system upgrade, MCP will initiate an independent third-party audit, prior to finalization of any system change or upgrade, to verify continued systems functionality per AHCCCS' requirements.

When an IT Change Control request is submitted, a new request is created in Remedy. Requests need to be approved by both the support group and the committee members. If an IT Work Request or an IT Change Control is not approved, or requires prior approval, it is sent back to the requestor with reasons for the denial. A system change may be minor (changes to access for an employee) or major (system migration or changes that impact operations). Minor system changes are processed, sent through the committee for approval, then confirmation of the change is provided to the employee's manager. A major change is sent to AHCCCS for approval before receiving authorization from the Change Control Committee. With approval, development and testing complete, the change moves to production. Please see the flowchart below describing the IT Change Control Process that MCP will use during this contract period.

IT CHANGE CONTROL NORMAL PROCESS DIAGRAM



13.





**Question 13 – Information Services**

Mercy Care Plan (MCP), through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, has access to comprehensive IT tools and solutions. This subcontract provides MCP with access to an IT organization that has efficiently and effectively supported the ALTCS contract for over 10 years and today serves over one million Medicaid health plan members in 10 states. Schaller’s IT organization is flexible and responsive, led by a Vice President of Technology Support with over 15 years’ experience. Schaller’s IT organization manages the selection, maintenance and operation of software applications, leveraging the deep skill set of personnel averaging over 10 years’ of role-related experience each. In some instances, software vendors staff their own personnel at Schaller’s offices to better assist in the support and maintenance of their respective software. The following table provides the details of Schaller’s software applications that support MCP’s core business applications.

**Core Business Applications**

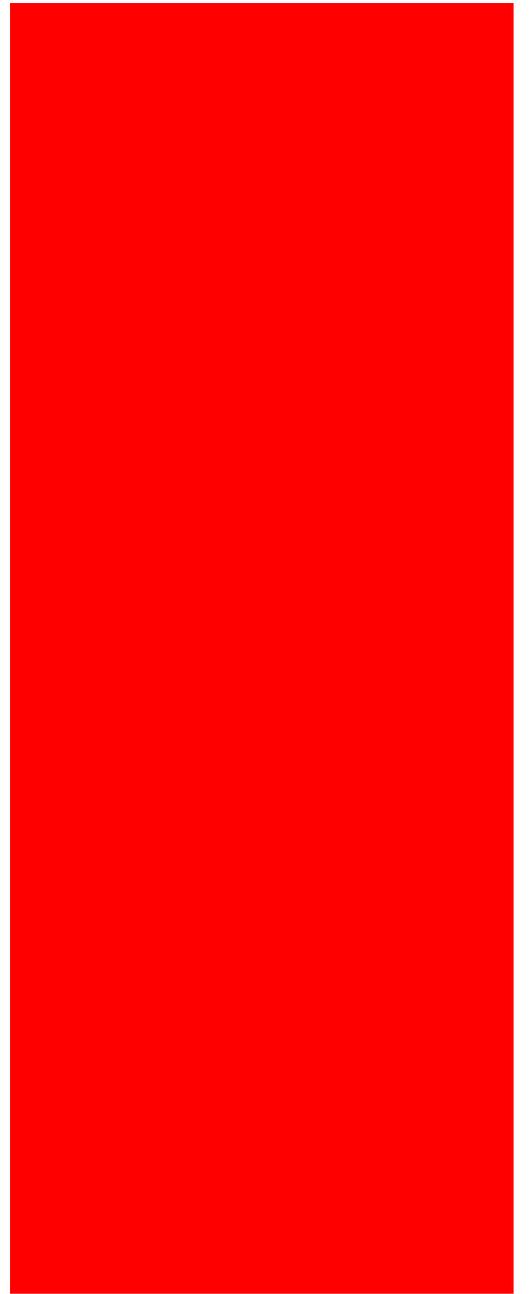
Functionality	Name	Ver/Rel	Years Supported	Currently Supported	Vendor Contact Contact’s Phone Number Contact’s email address Contact’s Address
Claims Processing	QNX™	3.4	20	YES	TriZetto/QCSI Heather Marberry (480) 414-7147 <a href="mailto:Heather.Marberry@trizetto.com">Heather.Marberry@trizetto.com</a> 14647 S. 50th St., Suite 150, Phoenix, AZ 85044
	ClaimCheck®	8.5	1.5	YES	McKesson Health Solutions Michael Cesarz (610) 993-4333 ext.1207 <a href="mailto:mike.cesarz@mckesson.com">mike.cesarz@mckesson.com</a> 5 Country View Road Malvern, PA 19355-1421
	iHealth	1.0	8	YES	iHealth Technologies, Inc. Jennifer Johnston (770) 913-2740 <a href="mailto:Jennifer.Johnston@iHealthTechnologies.com">Jennifer.Johnston@iHealthTechnologies.com</a> The South Terraces 115 Perimeter Center Place, Suite 700 Atlanta, GA 30346
	Outpatient Facility Services (OPFS) Pricer	1.2.090323	3.5	YES	Medical Data Express (MDE) Dave Abraham (480) 839-0420 <a href="mailto:dave.abraham@medicaldataexpress.com">dave.abraham@medicaldataexpress.com</a>

Functionality	Name	Ver/Rel	Years Supported	Currently Supported	Vendor Contact Contact's Phone Number Contact's email address Contact's Address
					2345 S. Alma School Road, Ste 105 Mesa, AZ 85210
Encounter Processing	EMS	7.3	7	YES	Internal MCP, Operations and IT Colleen Gurule (602) 659-1722 <a href="mailto:GuruleS@aetna.com">GuruleS@aetna.com</a> 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Case Management HCBS services tracking (PIP) Flu shot tracking (PIP) CATS data transfer	CaseTrakker Enterprise™	3.7.008	12	YES	IMA Technologies Lisa Schwenke (800) 458-1114 <a href="mailto:lisa@casetrakker.com">lisa@casetrakker.com</a> 1816 Tribute Rd, Suite 100, Sacramento, CA 95815-4323
Provider Credentialing, Quality of Care, Ambulatory Medical Record Reviews	VisionPro	1.0.2	12	YES	Health Line Systems Mark Sampson (800) 733-8737 <a href="mailto:MSampson@healthlinesystems.com">MSampson@healthlinesystems.com</a> 17085 Camino San Bernardo, San Diego, CA 92127
Provider/Member Web Portal Non-Provision of Services Log Gap in Services Log	MercyOneSource	3.2	12	YES	Healthation Laura Kampfhinkel (858) 617-6341 <a href="mailto:lkampfhinkel@healthation.com">lkampfhinkel@healthation.com</a> 12348 High Bluff Drive, Suite 200, San Diego, CA 92130
Data Mining and Analysis	ASDB	10.10.1	7	YES	Internal MCP, Actuarial Services and IT Tom Reese (602) 659-1130 <a href="mailto:ReeseT2@aetna.com">ReeseT2@aetna.com</a> 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040

Functionality	Name	Ver/ Rel	Years Supported	Currently Supported	Vendor Contact Contact's Phone Number Contact's email address Contact's Address
Predictive Modeling	Predictive Modeling	10.10.1	5	YES	Internal MCP, Actuarial Services and IT Paul Fawson (602) 659-1782 <a href="mailto:FawsonP@aetna.com">FawsonP@aetna.com</a> 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Member Health Risk Assessment	ActiveHealth	1.0	2	YES	ActiveHealth Management Gary Buccello (703) 995-6395 <a href="mailto:GBucello@activehealth.net">GBucello@activehealth.net</a> 102 Madison Avenue New York, NY 10016
Web Based Formulary	Epocrates®	1.0	1	YES	Epocrates Incorporated Sheryl Lowenhar (480) 699-1468 <a href="mailto:SLowenhar@epocrates.com">SLowenhar@epocrates.com</a> 1100 Park Place, Ste 200 San Mateo, CA 94403
Document Management	Alchemy	8.3	7	YES	EMDEON FutureVision Jeremy Gregersen 801.747.5815 <a href="mailto:jgregersen@fvtech.com">jgregersen@fvtech.com</a> 4548 S. Atherton Drive Taylorsville, UT 84123

\* Note: All of the core systems denoted in the table are in active use by MCP.

14.



## Question 14 – Information Services

Mercy Care Plan (MCP), through a subcontract arrangement with Schaller Anderson, LLC (Schaller), an Aetna company, has access to comprehensive IT tools and solutions. This subcontract provides MCP with access to an IT organization that has efficiently and effectively supported the ALTCS contract for over 10 years and today serves over one million Medicaid health plan members in 10 states. Schaller’s IT organization is flexible and responsive, led by a Vice President of Technology Support with over 15 years’ experience. MCP’s chief operating officer (COO) has the authority and responsibility to direct the activities, performance and outcomes of the IT subcontract.

Under the direction of our COO, Schaller’s IT organization maintains systems migration plans supporting compliance with current and future Federal IT mandates. In addition, Schaller dedicates considerable resources towards the development and maintenance of the business and systems infrastructure necessary to support such mandates, recent examples including HIPAA 5010 implementation and the adoption of ICD-10. Schaller has implemented solutions specifically engineered to address these mandates and their evolving requirements. For example, ClaimCheck® and iHealth, two claims auditing applications, enforce business rules pertaining to “medically unlikely” services and possess the functionality necessary to address pending edits regarding Hospital Acquired Conditions (HACs). Our 10 years’ experience as an ALTCS contractor leaves us ideally positioned to not only continue supporting the needs of Maricopa County’s ALTCS population, but to extend those services to Pima County’s ALTCS membership as well.

The design goal for MCP’s information system is to use powerful, reliable, and expandable data processing systems. The foundation of this platform is a redundant, high speed Local Area Network (LAN) and Wide Area Network (WAN) and clusters of servers with built-in redundancy. This approach provides 100 percent uptime for all core business systems in 2010. MCP’s network infrastructure consists entirely of Cisco routers, switches, and firewalls. Cisco standardization provides maximum latitude in equipment configurations. Cisco routers support our MPLS network, external traffic to the Internet, and connections to other private networks. Core business applications run on a cluster of Hewlett Packard ProLiant DL 380/580 servers. Each server is equipped with a minimum of two dual-core Intel processors and 4GB of RAM. Applications loaded on the server pool access data from high-end database servers. These 64-bit, Itanium class database servers attach to EMC and HP storage arrays via Brocade switches. This server configuration will provide all necessary computing power, redundancy, and scalability to meet both enrollment growth and an increase in requirements. MCP is able to add servers to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally. This scalability allows systems to match any escalation in demand associated with AHCCCS’/MCP’s performance requirements, while at the same time maintaining system uptime and performance. Network traffic and users accesses to the core application are load balanced by f5 Global Load Balancing services. MCP’s member services call center runs on a Schaller-supplied Avaya S8500 IP switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts.

The various steps, or stages, of our systems migration plan are as follows:

**Migration Planning:** Schaller’s system’s migration plans align with our standard Change Order Process (COP), beginning with a readiness assessment comprising a high level analysis of the strategy required to implement the requirements. Once the readiness assessment is completed, the project team defines the scope of work by developing a project charter with realistic and actionable plans for the overall project implementation. Key stakeholders are identified and a communication plan established and executed along with the project plan.

**Gap Analysis/Impact Assessment:** Schaller performs a gap analysis and impact assessments prior to any system conversion/upgrade, determining the potential impact to current business operations and defining and developing specific business and technical requirements within and across transactions. Each gap, as well as its respective solution, is then documented for subsequent validation via use case or test scenario.

**System Implementation:** Schaller will base system implementation planning on an inventory of systems and environments requiring modification prior to implementation of any additional functionality. Once systems are aligned and environments have been identified, associated translators are modified to accommodate required formats. This includes:

- Reviewing and updating mappings
- Modifying existing and incorporating new business rules as necessary
- Updating and applying custom edits

**Testing:** Schaller’s testing plans include defined transaction based test scenarios covering all systems, interfaces, transactions, and reports, including end-to-end testing with all clearinghouses, providers, system/software vendors and

third-party administrators as applicable. Data and results are reviewed and communicated with any entity involved in data submission, acceptance or processing to verify that expected results are accurate and issues resolved. Reports track results and validate testing activities, provide verification of the enhancements and serve as the platform for their migration to the production environment.

**Monitoring and Management of Performance:** Schaller performs post implementation reviews subsequent to any migration, monitoring the success rate of functionalities including, but not limited to: 1) Claim processing; 2) Timely claim adjudication; 3) Return of requested benefit information; 4) Accurate claim status inquiries; and 5) Accurate payment remittance advice and fund transfer. Schaller will develop control plans for compliance auditing and develop and distribute procedure manuals to help guide best practices around new business features and data. Perhaps most importantly, understanding that the changes in any one migration will not necessarily resolve every issue associated with its predecessor, we continuously assess our business operations for opportunities to enhance operational workflow and productivity. Schaller's systems configuration supports migration from one HIPAA version to another in the following ways:

- Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing MCP to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and from the full spectrum of HIPAA transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.
- Foresight HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing MCP to accept all compliant records that pass at a lower level of edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.

Schaller follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates. Following the WEDI, Schaller complies with the following federally mandated HIPAA transactions:

278 Inbound – prior authorization from providers  
820 Inbound – capitation file from state  
834 Inbound – eligibility file from state/employers  
835 Inbound – remittance file from state/remittance file to providers  
835 Outbound – remittance file to providers  
837 Institutional – inbound/outbound, claims file/encounter file to state  
837 Professional – inbound/outbound, claims file/encounter file to state  
837 Dental – outbound, encounter file to state  
NCPDP Inbound/Outbound – pharmacy claims file/pharmacy encounter file to state

Future implementations include:

270/271 – enrollment verification. MCP anticipates compliance within calendar year 2011  
275 – format will be supported once approved

To support successful implementation of ICD-10-Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS) on October 1, 2013, MCP has taken the following steps:

- An assessment was completed in 2010 to identify all operational and technical processes and systems that will be impacted by the upgrade to ICD-10 codes. This resulted in the identification of work streams that have started efforts to analyze, develop, test, and implement the upgrade of our processes to the new coding.
- Development and testing of the ASC X12 version of 5010 claim and encounter transactions was performed in 2010 to allow the receipt and delivery of ICD-10 codes. Production target dates for utilizing these transactions have been determined, and deployment will be completed by the January 1, 2012 compliance date.



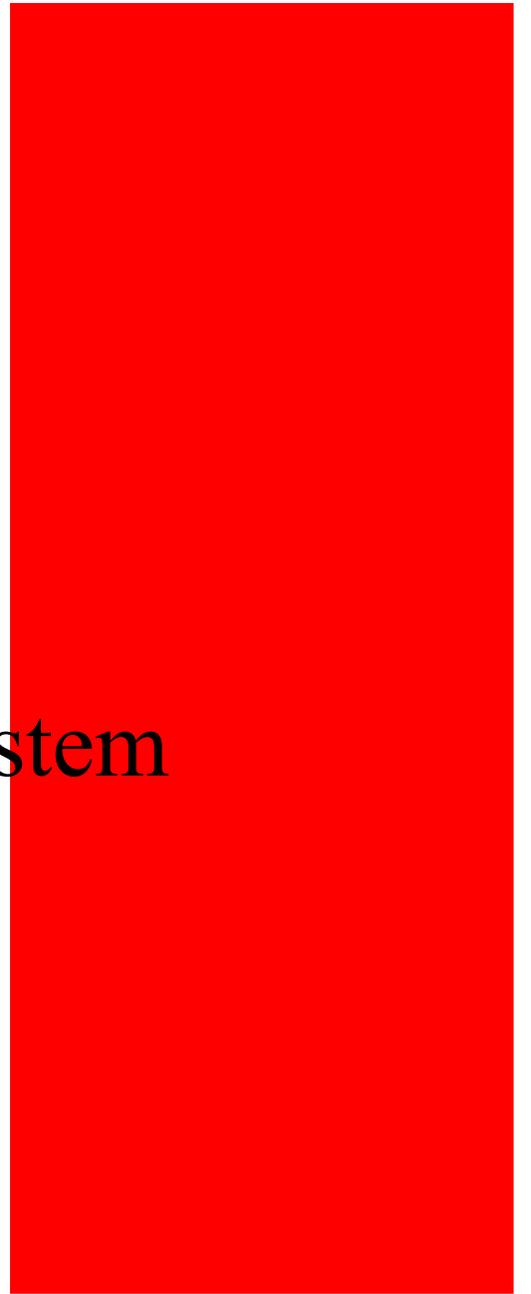
- The version upgrade that supports the acceptance and consumption of the ICD-10 codes within our QNXT™ adjudication system is targeted for 3rd quarter 2011.
- Workgroups have been developed to identify milestones for all ICD code-dependent processes and systems. Health plan operations will manage to these established target dates.
- MCP personnel attend all AHCCCS technical consortium meetings as required by AHCCCS' contract.

MCP provides for online claim inquiries via MercyOneSource, a HIPAA-compliant, secure web portal. In addition, we support proprietary electronic member eligibility request-response transactions using MercyOneSource. The MCP online verification tool has the same functionality as the AHCCCS Medifax application; however, it adds the primary care physician assignment, provider contact information, and provider eligibility dates to the data received. The website recorded over 722,000 logins in calendar year 2010, with providers using this specific functionality to perform over 1.06 million eligibility checks.

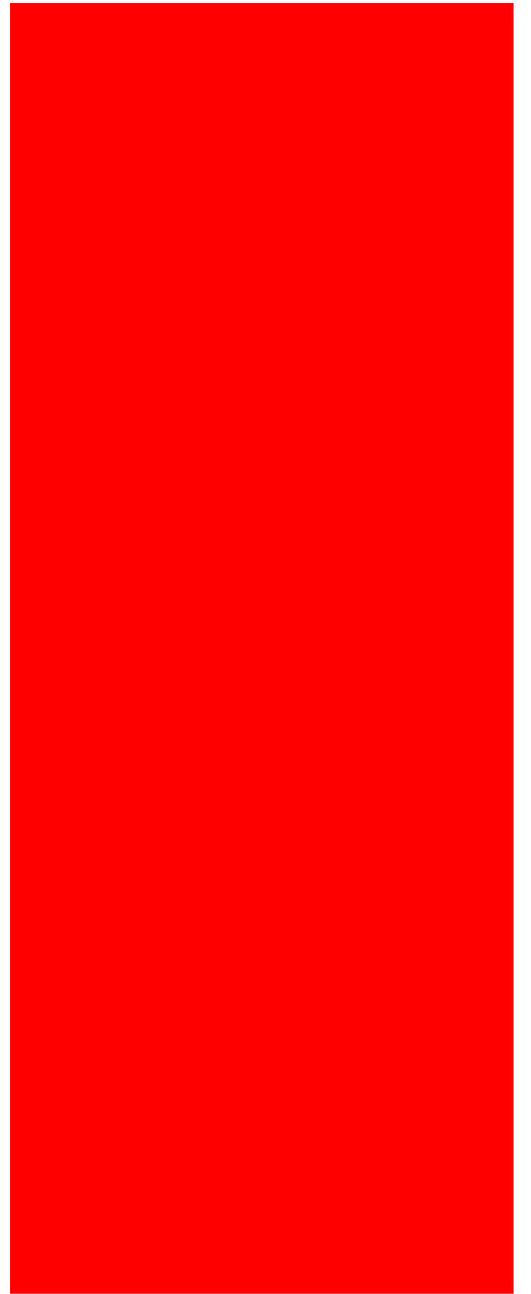
MCP is currently compliant with all HIPAA and other federal IT mandates, and MCP IT personnel regularly attend national seminars, review professional journals, and monitor the U.S. Department of Health and Human Services and AHCCCS websites to monitor and prepare for any future mandate. All MCP and Schaller personnel are required to attend mandatory HIPAA awareness training, where they are instructed on confidentiality, privacy, information safeguards, and penalties imposed for noncompliance.

MCP is prepared to respond to any AHCCCS or Federal programmatic changes that would impact IT processes, requirements, or systems.

# Grievance System



15.



## **Question 15 – Grievance System**

In accordance with AHCCCS regulatory requirements, Mercy Care Plan (MCP) bases its grievance system on written Policies and Procedures (P&Ps), and protocols that are updated at least annually or as necessary due to changes in regulation. MCP designed its grievance system to meet AHCCCS turnaround times and protect confidentiality and privacy of our members and the security of our members' Protected Health Information (PHI). Our grievance system responds to and supports all member or provider requests for state fair hearings.

MCP's Vice President of Member Services has responsibility for our grievance process and our Dispute and Appeal Manager has oversight of our appeals process; both work under the direction of the Chief Operating Officer (COO). These employees work with other MCP departments (e.g., including but not limited to: medical management, claims, provider services, health plan operations (HPO), case management, behavioral health, utilization management, quality management) to resolve grievances, appeals, and claims disputes.

Under the direction of the COO, MCP since 2009 has maintained two inter-departmental and cross-functional workgroups (e.g., Grievance Workgroup and the Appeals Process Improvement Workgroup). The purpose of these workgroups, which meet weekly, is to identify trends and root causes for grievances, appeals, and claims disputes. These workgroups report their findings directly to the Quality Management/Utilization Management (QM/UM) Committee with recommendations to implement interventions to improve MCP's operational performance.

MCP, in proposing to add the Pima and Santa Cruz GSA, examined the scalability of its grievance system to accommodate enrollment growth. As a result of this examination, MCP has determined that its grievance system, including its grievance and Appeals Databases, are scalable to meet both enrollment growth and increases in AHCCCS specifications or requirements.

Our members and their families/caregivers are educated regarding their grievance, appeals, and State Fair Hearing rights by their Case Manager (CM) during the initial in-person assessment. The CM gives and reviews with the member a new member packet. This packet includes a: a) member handbook, b) provider directory including a zip code specific urgent care listing, c) information on HIPAA, d) member rights and responsibilities acknowledgement, e) Critical Service Gap Report Form, f) self-directed attendant care pamphlet, and g) advance directives form. The CM thoroughly reviews items from the member handbook such as: instructions on how to file a grievance or appeal or request a State Fair Hearing; the entire spectrum of Long Term Care (LTC) services; behavioral health crisis line; translation and transportation services. At the same time, the member and member's family/caregiver<sup>1</sup> are advised that if the member or member's family/caregiver is unable to file a grievance or appeal themselves, their CM, as the member's advocate will assist the member or member's family/caregiver in completing the process. MCP provides language interpretation services to our members at no cost. All documents are written at the appropriate grade level for ALTCs members and translated or available in all prevalent non-English languages or in alternate formats. The member or member's family/caregiver is asked to sign a member packet acknowledgement form indicating they have received all the information described above, that items have been reviewed and that they understand what has been received. In addition, this information is also available on our website and at no cost to the member or the member's family/caregiver by contacting either the CM or our Member Services Department (via our toll-free line).

### **Member Grievances**

Even though MCP's enrollment increased CY 2009-2010, during this same period we had a 36 percent decrease in member grievances. Although there are many factors that may have affected this decrease in member grievances, one major influence was improvements in our process for recognizing, receiving, managing, and resolving member grievances. For instance, when a LTC CM or a Member Services Representative (MSR) receives a grievance, either in person or by telephone, letter, or e-mail, this employee documents the grievance using our standardized electronic Grievance Form. The form is electronically forwarded to member services to be entered into the grievance management system. The LTC CM, MSRs, and any other employee who may receive a member grievance are required to attend and successfully complete training on the Grievance Database and how to complete the Grievance Form (This training is mandatory upon initial hire and annually thereafter.)

The employee who receives the member grievance completes the Grievance Form and assigns a grievance category type (e.g., accessibility/availability, cultural barriers/insensitivity, etc.). The employee receiving the grievance acknowledges the grievance verbally when it is received (in person or via the telephone). If the grievance is received in writing, a written acknowledgement response is sent to the member or member's family/caregiver within five business days. All Grievance

---

<sup>1</sup> Hereinafter, all references to "family/caregiver" include the member's guardian.

Forms are reviewed by a Member Services Manager. The purpose of this review is to verify that a grievance resolved with the member or member's family/caregiver at the time it is received, was categorized, and resolved in accordance with MCP's P&Ps. If at the time of the grievance receipt, the employee who receives it is unable to resolve the grievance with the member or member's family/caregiver, the Grievance Form is electronically transmitted to a member services manager for research, management, and resolution.

MCP receives two types of member grievances: 1) a service grievance, and 2) quality grievance. The process for recognizing, receiving, managing and resolving both types of member grievances is described below.

Service grievances received from members or the member's family/caregiver include, for example, members' dissatisfaction with the consistency of services, but do not involve clinical/quality concerns. Typically, the CM or MSR, based on their training and experience, are able to resolve these grievances immediately. For instance, in 2010, more than 99% of member grievances were resolved in less than one day. If an immediate resolution is impossible, the employee receiving the grievance verbally informs the member or member's family/caregiver that additional research is necessary and that the member or member's family/caregiver can expect a resolution within 90 calendar days.

Quality grievances received from members or members' family/caregiver involve issues related to quality of care or treatment (e.g., alleged inadequate medical care). After documenting the quality grievance on the Grievance Form, the CM or MSR forwards the grievance to their manager for review. If the grievance is a potential quality grievance, the manager on the same day delivers the grievance to the QM Department for review and investigation. All quality grievances are acknowledged in writing within five business days. Clinically trained QM review nurses and the designated medical director research and resolve these grievances (involving the Peer Review Committee, if appropriate). Upon resolution, the QM Department notifies the member services manager and the Long term care manager that the issue is closed and provides a response letter indicating resolution that is sent to the member within 90 calendar days.

A cross functional workgroup, chaired by the Member Services Manager and comprised of leaders from member services, provider services, case management and quality management, meets weekly to review all grievances received the previous week. The team determines if each grievance is resolved or needs additional intervention and addresses any issues immediately. Outcomes of any interventions are reported to the CM and the MSR who accepted the grievance so they can advise the member of the final outcome.

## **Member Appeals**

MCP provides members, or members' families/caregivers, information regarding their right to appeal adverse actions taken by MCP. Members may file appeals with the Appeals Department verbally or in writing up to 60 calendar days after the date on MCP's Notice of Action (NOA). The member or member's family/caregiver may appeal an action taken by MCP to deny a request for prior authorization, suspend or reduce a previously authorized service, or terminate a previously authorized service. In addition, a member or member's family/caregiver may file an appeal for failure to provide a service or process a grievance or appeal in a timely manner. The member or member's family/caregiver may request that a previously authorized service continue during the appeal process provided that the appeal is filed within 10 calendar days of the date of the NOA and all other regulatory standards are met. Members may also ask that their appeals be expedited if the time required for the standard appeal process would seriously jeopardize their life, health, or ability to attain, maintain, or regain maximum function. MCP works closely with members and, as appropriate, providers to obtain additional information or supporting documentation for an expedited appeal requests.

The Appeals Department supervisor, with support from appeals coordinators, has day-to-day responsibility for managing member appeals.

### ***Standard Appeals Process***

MCP's appeals coordinator receives all appeals, assigns each appeal a tracking number, logs the appeal information into the Appeals Database, and creates a file including all related documentation. Within five business days of receipt, MCP acknowledges each appeal in writing.

The appeals coordinator conducts a thorough investigation of each appeal by reviewing the substance of the appeal request; the initial adverse action notes and records; additional clinical information and documentation submitted by the member, the member's family/caregiver, or the member's physician or treating provider; all aspects of clinical care involved; and specialty reviewer comments. For appeals related to service denials based on lack of medical necessity or involving clinical issues, the appeal is routed to the Chief Medical Officer (CMO) or designated Medical Director who was not involved in any previous level of review or decision-making and who has the appropriate clinical expertise to treat the member's condition or issue. Unless an extension is granted, the Appeals Coordinator renders a decision on 100

percent of appeals within 30 calendar days of the appeal receipt date. An extension will grant an additional 14 calendar days from the date of appeal receipt.

### ***Expedited Appeals Process***

When a member requests an expedited appeal, the appeals coordinator processes it in compliance with our expedited appeal processing guidelines. The appeals coordinator immediately escalates the expedited appeal request to the CMO or designated medical director for review. The CMO or designated medical director initially reviews the expedited appeal request to determine whether or not it meets the designated criteria: if the time standard appeal process is followed it would seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. All expedited appeals are acknowledged by the appeals coordinator in writing within one business day and resolved within three business days. If the determination is made that the appeal does not fit the criteria for an expedited appeal, the member or member's family/caregiver is notified by the appeals coordinator in writing, and the appeal is transferred to the standard appeal process.

### **Provider Claims Dispute Process**

Any contracted or non-contracted provider may file a claim dispute with MCP. Our Appeals Supervisor, reporting to the Dispute and Appeal Manager and supported by Provider Appeals Coordinators, is responsible for executing the provider claims dispute process.

MCP accepts all written claim disputes. We log the information about the dispute into our Appeals Database and, within five working days of receipt, send the provider a letter acknowledging receipt of the dispute. The dispute is assigned to a Provider Appeals Coordinator who uses applicable statutory and regulatory requirements, provider's contractual provisions (if any), and MCP's P&Ps to thoroughly investigate the basis for the dispute. The coordinator reviews all available documentation, authorizations, claims activities, and member eligibility information. If appropriate, the coordinator refers the claims dispute to the CMO or delegated medical director for clinical review to determine the appropriate action regarding the dispute. All claim disputes forwarded for a provider review require a five (5) business day turnaround.

The Provider Appeals Coordinator renders a decision on the ALTCS claims dispute within 30 calendar days of receipt, the decision is entered into our Appeals Database, and a Notice of Decision (NOD) is sent to the provider. The NOD includes details about the dispute, the issues involved, the reasons for MCP's decision and applicable statutory and regulatory requirements, provider's contractual provisions (if any), and MCP's P&Ps. If the claims decision is overturned, MCP will process and pay the claim consistent with the recommendation within 15 business days; if applicable, we will include interest into our payment.

### **State Fair Hearing (SFH) Process**

Upon receiving a member or provider SFH request, the MCP SFH coordinator logs the information into the Appeals Database and forwards the complete request including any relevant or required documentation to the AHCCCS Office of Administrative Legal Services within five calendar days. When the hearing is scheduled, we document the date of the SFH in the Appeals Database. Generally, MCP's SFH attorney and applicable MCP employees will attend the SFH and offer evidence as appropriate. If the AHCCCS Director's decision reverses MCP's original decision to deny, limit, or delay services not authorized while the appeal was pending, MCP promptly authorizes the services as quickly as the member's health condition requires. If the AHCCCS Director's decision reverses MCP's original decision to deny, limit, or delay services, and the services were continued at the request of the member or member's family/caregiver during the appeal, we promptly authorize the services with an effective date equal to the date of receipt of the original appeal.

### **Using Data from the Grievance System to Improve Operational Performance**

MCP views appeals and grievances as indicators of potential process improvement opportunities. Under the direction of the COO and with support of the VP of Member Services and the Dispute and Appeal Manager, data from the grievance system is used to identify opportunities to improve provider performance and our operations (i.e., medical management, claims, provider network, etc.). Using the Plan-Do-Study-Act (PDSA) model, MCP, even with an increase in enrollment achieved a 63 percent decrease in ALTCS claims disputes and appeals and a 36 percent decrease in member grievances in CY 2009-2010.

Under the direction of the COO, the VP of member services and the dispute and appeal manager collect, trend, and analyze grievance system data. MCP, in 2009, formed two workgroups – one addresses trends and analyzes member grievance data and the other addresses trends and analyzes member appeals and provider claim disputes. The member grievance workgroup is led by the VP of member services. The member appeals and provider claim dispute workgroup is

led by the dispute and appeal manager. Both workgroups have inter-departmental and cross-functional membership, including all relevant operational departments: ALTCS case management, provider services, health plan operations, claims, and quality management. Each workgroup identifies opportunities for improvement, recommends interventions, evaluates the effectiveness of those interventions and presents recommendations to the QM/UM Committee for approval. Our Member Advisory Committee also provides inputs to this process.

Our Grievance Database and Appeals Database were each custom designed to capture, store, and retrieve detailed information on grievances, appeals, or claim disputes. Using these databases, MCP produces a suite of management reports, with capabilities to drill down to identify root causes. We generate ALTCS specific reports by multiple combinations of data elements tracked in these Databases.

As part of their quality improvement processes, other operational areas use grievance system data results along with other data sources (e.g., provider utilization patterns, satisfaction survey results) to identify improvement opportunities.

Below are examples of action steps and outcomes of operational improvements identified and implemented by the workgroups.

**Example 1:** In 2010, the Grievance Workgroup reviewed trends from the annual grievance report identifying 36 PCP outliers above two standard deviations from the mean. The workgroup then recommended enhanced outreach efforts to these providers. Examples of the corrective actions we implemented include closing provider panels to auto assignment and face-to-face visit with the CMO, medical director, or provider relations representative. Where appropriate, our range of action can include termination from our network.

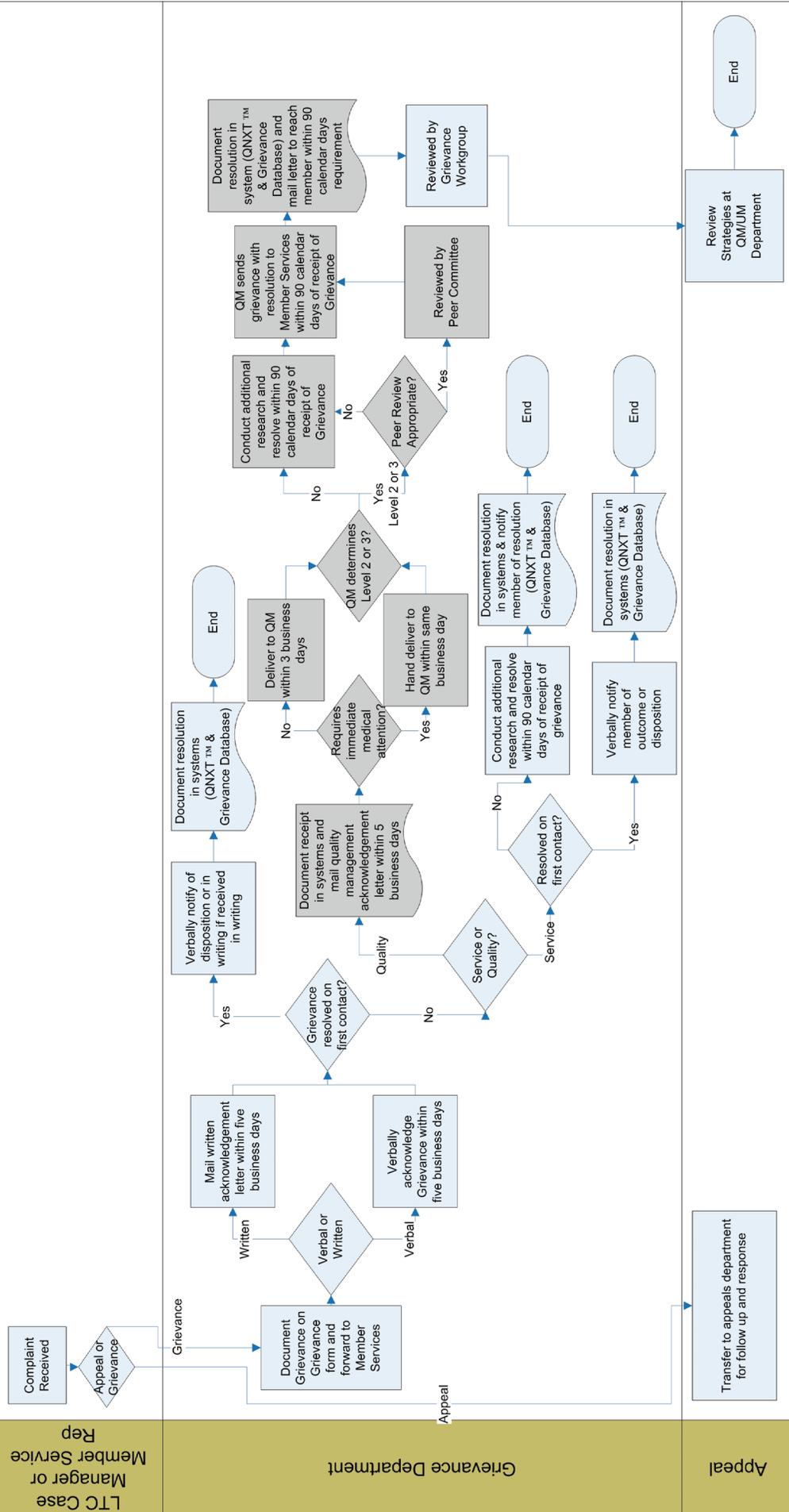
**Example 2:** It is our standard operating procedure to send all transportation-related (provider no-show or delay) member grievances to QM for quality of care investigation. Based upon findings from QM and our analysis of trends, interventions to improve transportation services were developed. One of the results of these interventions was to contract with an additional transportation provider to increase consistency, accessibility, and availability of services. As a result of this intervention, transportation grievances decreased by seven percent as compared to the previous year (CY 2009-2010). Also, the Member Advisory Council offered suggestions to explore methods to reduce the “no-show” rate by better educating members about their responsibility to be ready when their requested transportation provider arrives and to provide adequate notice when canceling a ride. This suggestion was added to the Member Handbook to further educate our members.

**Example 3:** In 2009, MCP’s Appeals Workgroup identified a specific provider with an unusually high pattern of claim denials that were inappropriately denied. As a result of drilling down into the root cause of these denials, it was determined that the provider’s contract had been loaded incorrectly in our claims processing system (QNXT™). Based on this analysis, the Appeals Coordinator expeditiously began working with the Provider Data Services (PDS) team that is responsible for the accuracy and integrity of provider contract loads in QNXT™. The PDS team diagnosed the configuration problem and after appropriate testing implemented system configuration updates. As a result, we reduced by more than 90 percent the number of claims disputes submitted annually by this large provider group.

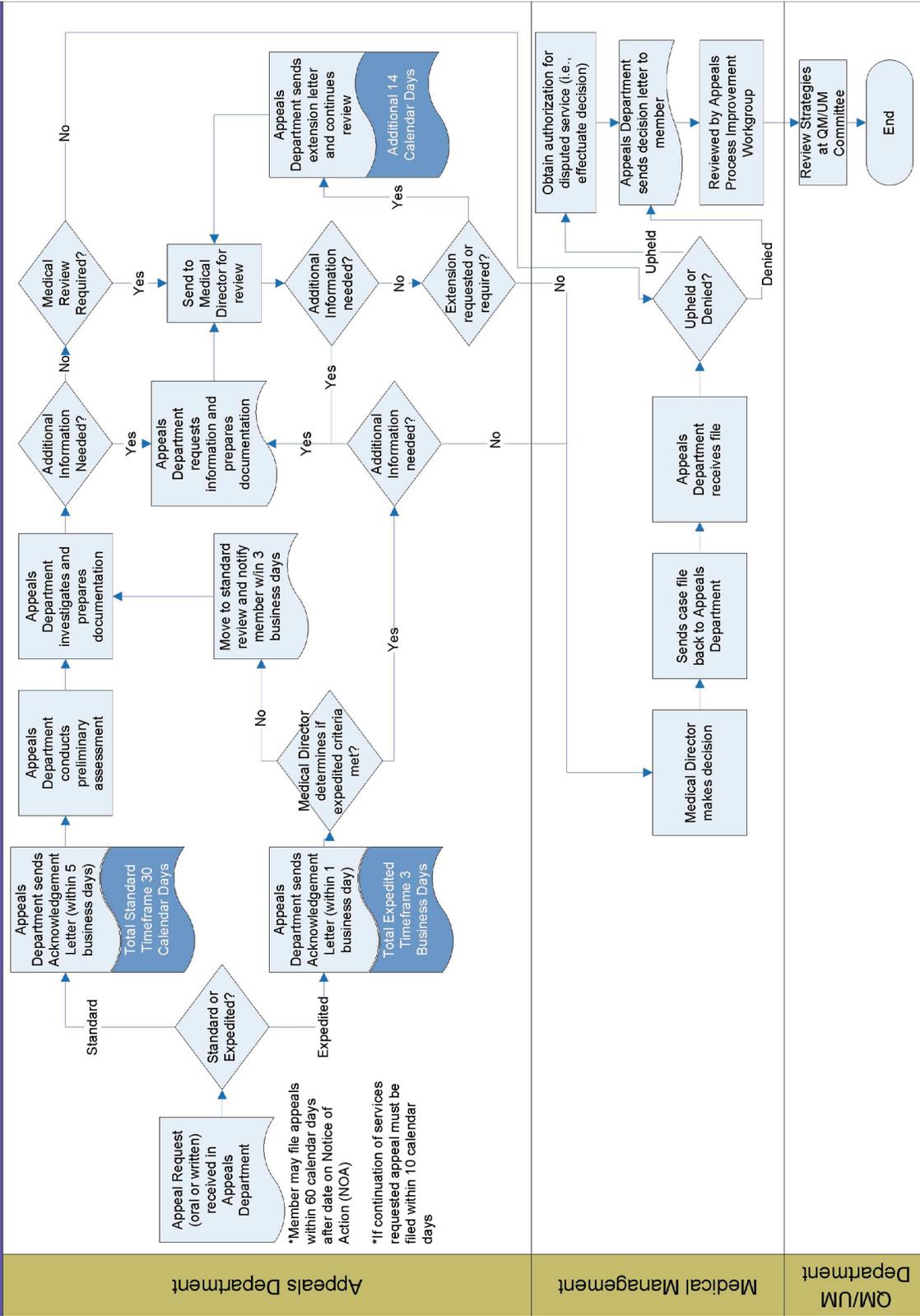
MCP respects and values our relationships with members and providers. The member grievance and appeals process and provider and subcontractor claim dispute process are important tools to make sure that we are providing our members and providers with the highest quality and most responsive service. Under the direction of our COO and with support from our VP of Member Services and our Dispute and Appeal Manager, MCP has implemented a grievance and appeals process and provider and subcontractor claims dispute process that encourages and effectively responds to member and provider concerns. MCP consistently meets or exceeds AHCCCS turnaround times for member grievance and appeals and provider and subcontractor claim disputes. MCP uses the results of member and provider input through these processes to identify opportunities for process improvement. Our overriding concern has been, and will remain, the safety, quality of care, accessibility and availability of medically necessary, and covered services for our members. Through our innovative ALTCS CM program, we consistently bring the member grievance and appeal process as close and responsive to the member as possible.

Our flowcharts for our member grievances, member appeals and provider claims dispute processes are provided on the following pages.

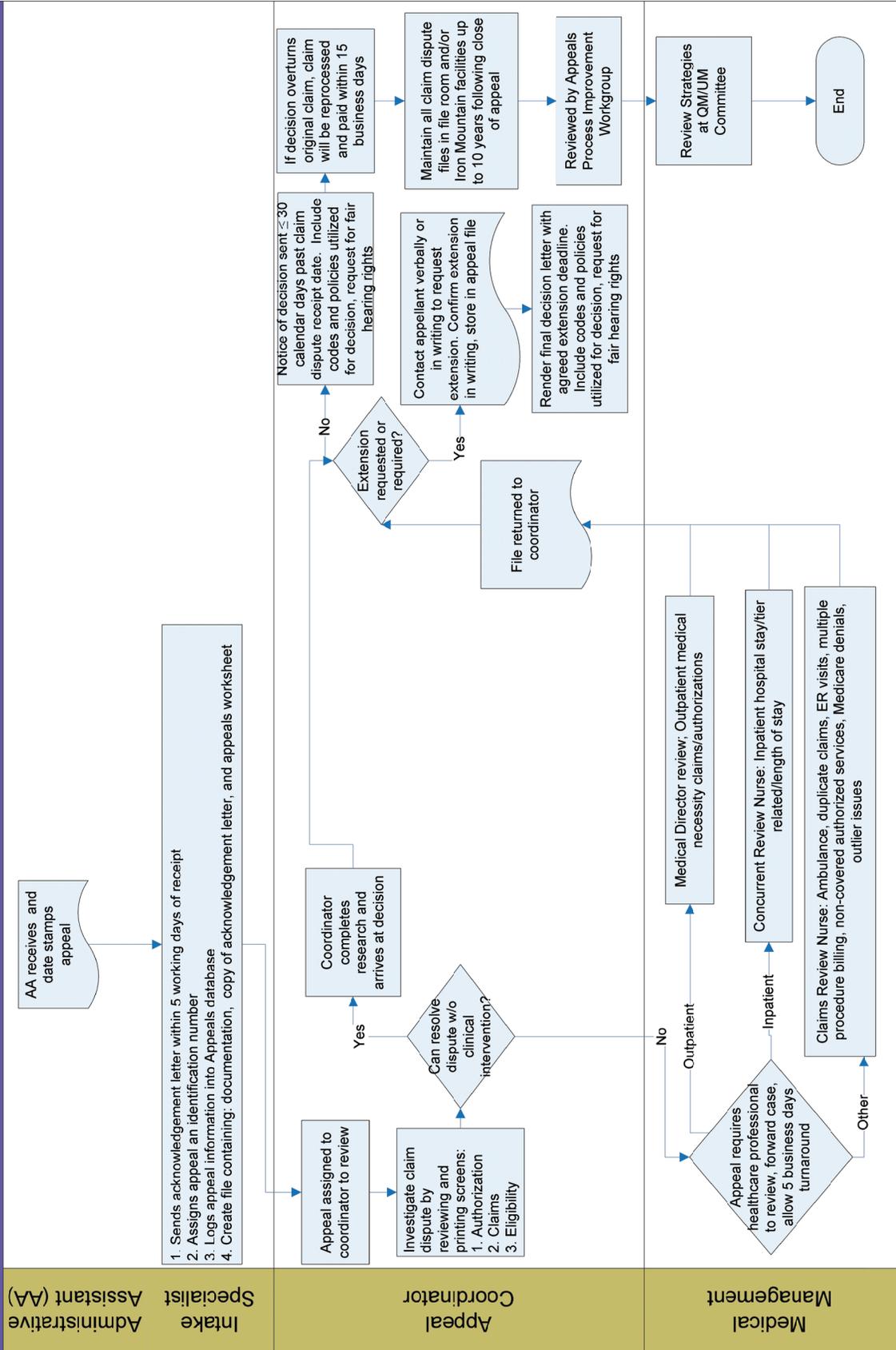
## Member Grievance Process & Quality of Care Grievance Process



## Mercy Care Plan Member Appeal Process



## Provider Claim Dispute Process

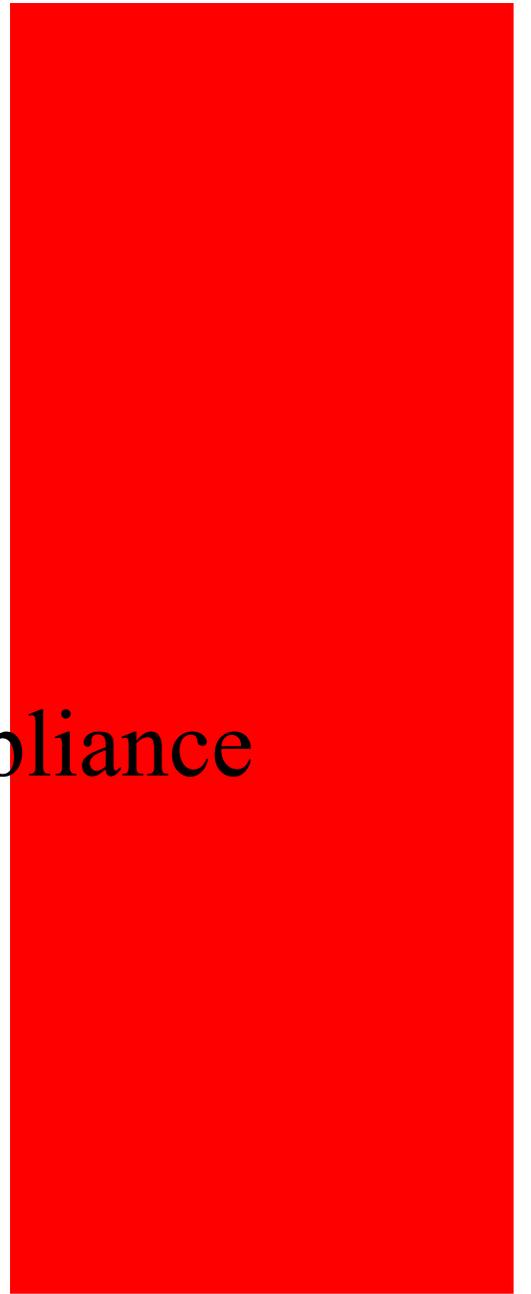


Intake Specialist  
 Administrative (AA)

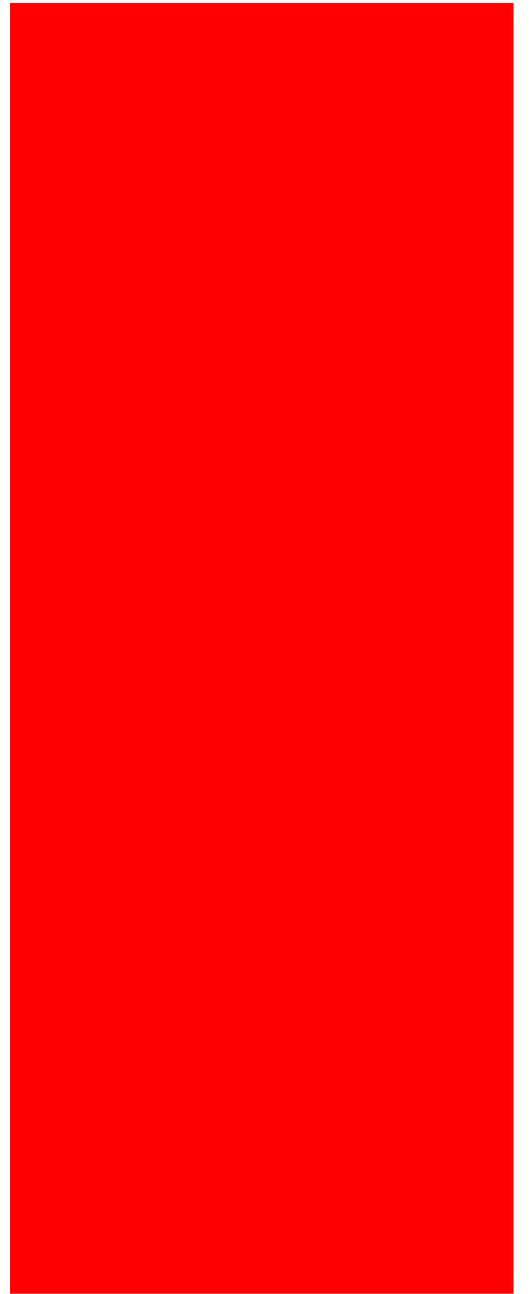
Appeal Coordinator

Medical Management

# Corporate Compliance



16.



## Question 16 – Corporate Compliance

The Mercy Care Plan (MCP) compliance program is based on comprehensive written policies, procedures, and standards of conduct promoting MCP's commitment to compliance with AHCCCS' and CMS' regulations, contractual requirements and organizational Policies and Procedures (P&Ps). The primary functions of our Compliance Department are to: 1) coordinate the tracking and submission of contractual compliance deliverables; 2) consult with and respond to AHCCCS regarding compliance concerns and issues; 3) educate and train employees on compliance requirements; 4) field and coordinate responses to electronic; telephonic and written inquiries and/or requests from the AHCCCS Office of the Inspector General (OIG); 5) coordinate the preparation and execution of operational and financial reviews, random, and periodic audits, and ad hoc reports and regulatory visits; and 6) immediately respond to, investigate, and report, as appropriate, all suspected fraud and abuse cases.

*Our 2010 AHCCCS ALTCS Operational and Financial Review found MCP to be in full compliance for all corporate compliance standards.*

### Levels of Authority

The Southwest Catholic Health Network (SCHN) Board of Directors has delegated the design, maintenance, administration, monitoring, and daily functioning of the MCP compliance program to our Compliance Officer (CO), who has a direct reporting relationship to our Chief Executive Officer (CEO). Our CO has authority and responsibility to lead, monitor, and administer the MCP compliance program across all levels of the organization and serves as the primary point of contact for all operational compliance issues. The job duties and responsibilities of the CO require active participation in each of the following federally required Medicaid compliance program areas under the provisions of §42 CFR § 438.608:

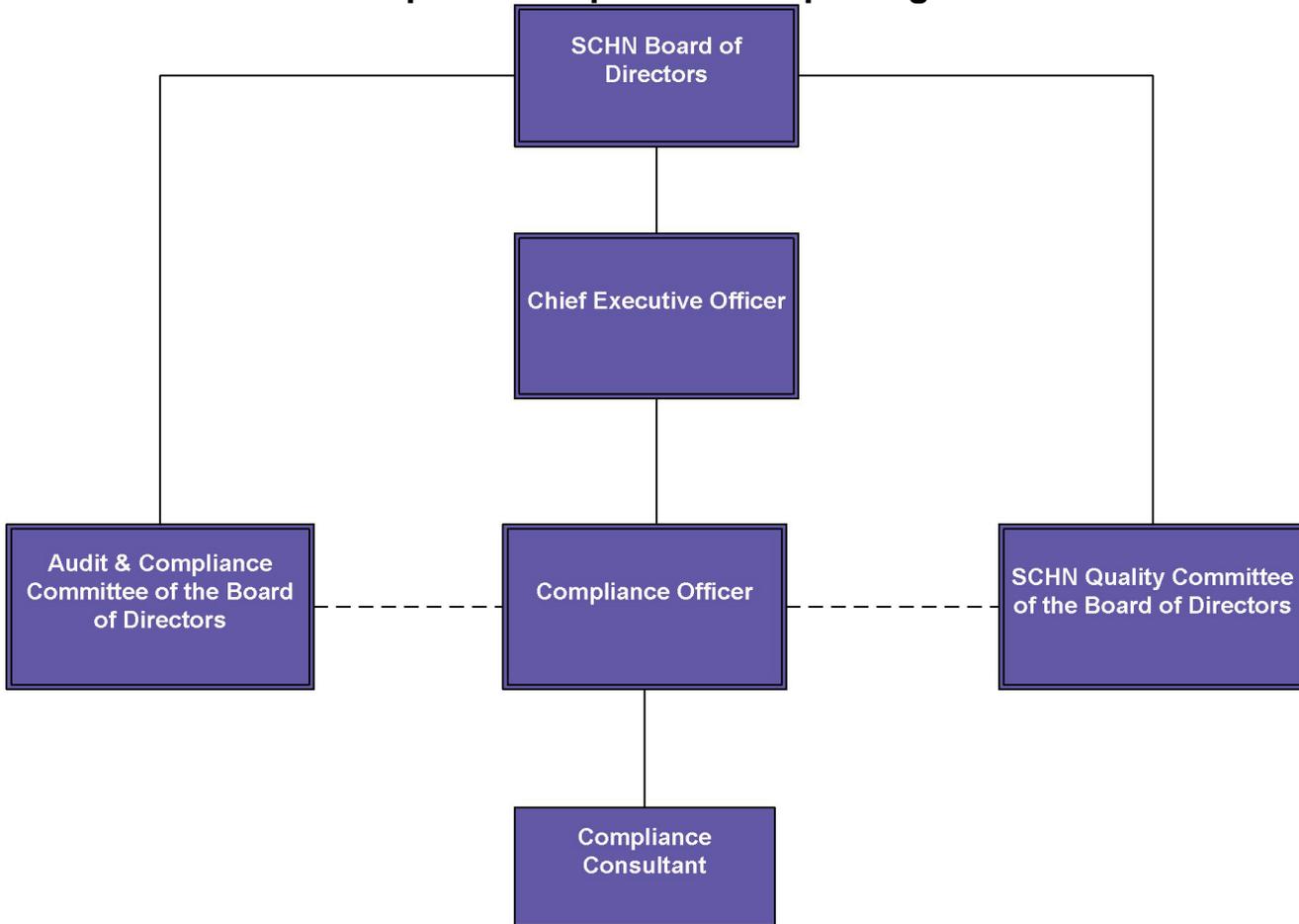
- Policy/standards of conduct
- Accountability to senior management
- Effective lines of communication
- Training/education of employees, members and providers
- Enforcement standards and disciplinary guidelines
- Internal monitoring and auditing
- Responses to detected offenses and corrective action

Our CO and Compliance Department personnel possess independent authority and system access to: 1) request, assess and review records; documents and functions as they relate to fraud and abuse prevention, detection, and reporting or other compliance related matters; 2) independently refer suspected member or provider fraud and abuse cases to the AHCCCS OIG or other duly authorized regulatory and enforcement agencies within 10 business days of discovery; 3) comply and cooperate with all requirements of OIG onsite reviews; and 4) initiate independent reviews of providers, programs, or personnel.

### Reporting Relationships

The organizational chart on the following page demonstrates the reporting structure of the MCP Compliance Department.

## Mercy Care Plan Compliance Department Reporting Structure



### ***Compliance Officer***

While the CO is ultimately accountable to the SCHN Board of Directors, the CO reports directly to the CEO and has direct access to senior management and legal counsel at all times. Our CO is a full-time, Arizona based employee of our senior management team and serves as MCP’s contract compliance officer. MCP has developed written criteria that outline the responsibilities and authority of the CO position as well as a job description that clearly defines required and essential skills and experience. To facilitate and support an open-door policy, immediate accessibility, and high visibility among employees, our CO attends staff and operational meetings, and participates in compliance components of our new hire and ongoing training sessions and acts as the privacy officer.

### ***Audit & Compliance Committee***

Under the direction of the CEO, our Audit & Compliance Committee of the Board of Directors is responsible for monitoring the compliance program and advising our CO on interventions for improving program effectiveness. The Audit and Compliance Committee is comprised of several SCHN Board members along with key MCP executives. The committee meets at least quarterly and the internal audit personnel who support the committee maintain minutes from each meeting. Specific committee activities include, but are not limited to: 1) overseeing maintenance and revision of all compliance program policies and other related documents; 2) reviewing and approving compliance reports as well as corrective action plans resulting from AHCCCS and federal regulatory audits; and 3) initiating and directing investigations related to any identified potential compliance gaps. Our Audit & Compliance Committee chairperson reports all compliance issues to the SCHN Board of Directors and appropriate subcommittees of the Board.

### ***Health Plan Business Operations***

Recognizing the importance of contract compliance for our organization, providers, and material subcontractors, our CO meets weekly with our Health Plan Operations Department to discuss potential compliance issues, identify resolution strategies, develop action plans, and determine follow up activities. Our experienced business operations analyst is responsible for analyzing claims data to identify inappropriate, concerning, or high-dollar billing trends. Upon detection

of potential issues, our analyst notifies the CO who assists in coordinating and completing the investigation process with other departments including, but not limited to, network management, quality management, and provider services.

### ***Prevention, Detection and Reporting of Fraud and Abuse***

Understanding that ALTCS members are diverse and vulnerable, MCP's compliance program is designed to guard against potential fraud and abuse. We regularly review and utilize the following resources to effectively prevent, detect, and investigate fraud and abuse as well as evaluate our system-wide compliance with federal/state laws and regulations and contractual requirements:

- Claims system edits
- Medical management, prior authorization, and utilization review oversight activities
- Front line employee resources, including member services, case management, provider services, quality management employees, and prior authorization
- Member appeals and grievances
- Provider credential validation at both initial and re-credentialing
- Verification of receipt of paid services audits
- Corporate audit service's periodic and routine internal random audit reports

*In 2009/2010, MCP referred 36 fraud and abuse cases to the AHCCCS OIG for investigation.*

Upon identification, our CO immediately reports potential fraud and abuse issues to the AHCCCS OIG as well as MCP's corporate Special Investigations Unit (SIU). The SIU is an operational unit that supports the detection, investigation, and reporting of violations by providers, subcontractors, employees and members. SIU analysts provide consultation to our CO and assistance during fraud and abuse investigations when appropriate.

### **Compliance Training and Education**

MCP promotes the importance of education and training in protecting our members and meeting legal and contractual compliance requirements. As a result, we have developed a comprehensive training program designed to promote compliance at all levels of MCP's organization and within our provider network as well as assisting and empowering our members in recognizing and reporting fraud and abuse.

#### ***Employees***

MCP employees comply with the provisions of our compliance program and complete initial and ongoing mandatory training sessions. The compliance training program includes new employee training, additional departmental specific training that is related to their assigned duties and unit functions, mandatory annual refresher for all employees, and ad hoc training as issues are identified. Upon completion of training, our employees acknowledge understanding of training goals and adherence to compliance program requirements. The Compliance Department maintains attendance and participation records in accordance with AHCCCS record retention standards. The MCP Compliance Department confirms that MCP employees continually receive updated, accurate, and timely compliance information through policy and procedure updates, company intranet site, as well as our internal email and electronic folder system.

#### ***Members***

MCP empowers our members to recognize, prevent, and report suspected fraud and abuse. We train CMs to recognize potential fraud and abuse concerns through interaction with members and providers, and to supply compliance reporting information and forms as needed. Our CMs have frequent and direct contact with our members and are the primary source for educating our members and members' families/caregivers regarding the process for reporting potential fraud and abuse. CMs report all potential fraud and abuse information to the Long term care manager who follows MCP policy and procedures in reporting the suspected fraud and/or abuse to the Compliance Department. Members also receive information regarding fraud and abuse through our member handbook and website.

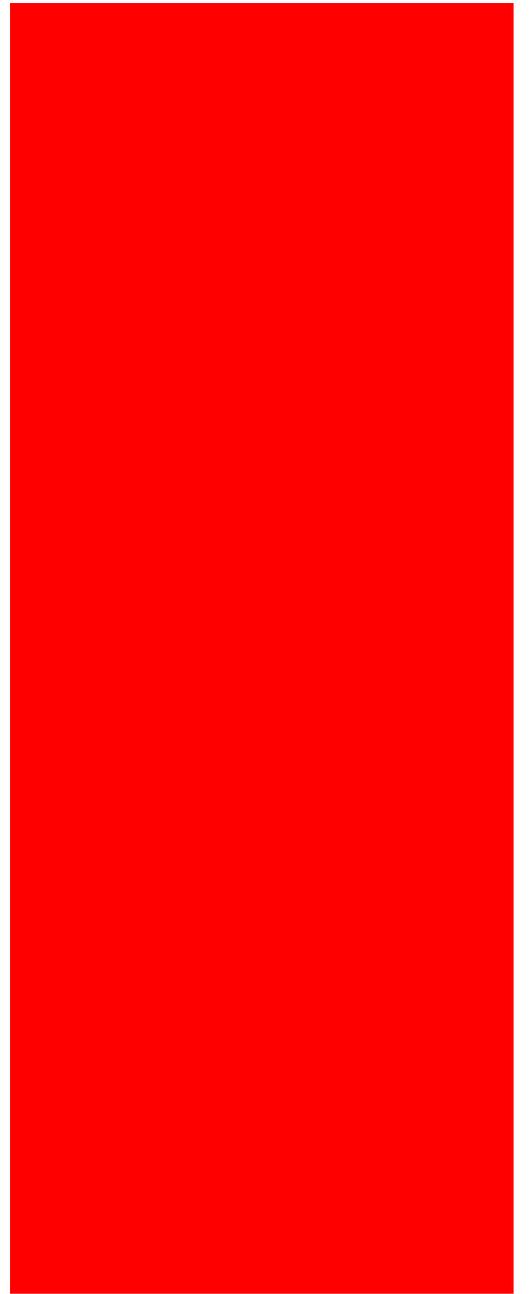
#### ***Providers***

MCP utilizes an array of communication mechanisms to promote open, two-way communication with providers for the receipt and dissemination of compliance information including in-service trainings, provider manuals, provider newsletters, provider website portal, and direct emails. MCP network providers must comply with the MCP compliance program, including fraud and abuse, and receive initial and ongoing training sessions. Provider contracts describe the provider's compliance responsibilities and our provider services representatives provide initial compliance training for providers as well as ongoing, on-site training related to updates and changes. MCP's Provider Services Department is responsible for conducting and maintaining all provider training modules and documentation.



# Finance and Liability Management

17.





### Question 17 – Finance and Liability Management

As an existing ALTCS contractor, Mercy Care Plan (MCP) has submitted the required audited financial statements for the fiscal years ending June 30, 2008, 2009 and 2010. As shown in the table below these financial statements demonstrates MCP’s continuing financial strength and our plan stewardship over the years. For almost 20 years, MCP has been in good standing with all AHCCCS financial viability measures.

MCP has a sizable investment portfolio that collateralizes our required performance bonds. As of January 31, 2011, MCP had almost \$190,000,000 of long-term and short-term investments. Investments are governed by a conservative investment policy that supports both the AHCCCS guidelines and our mission based philosophy.

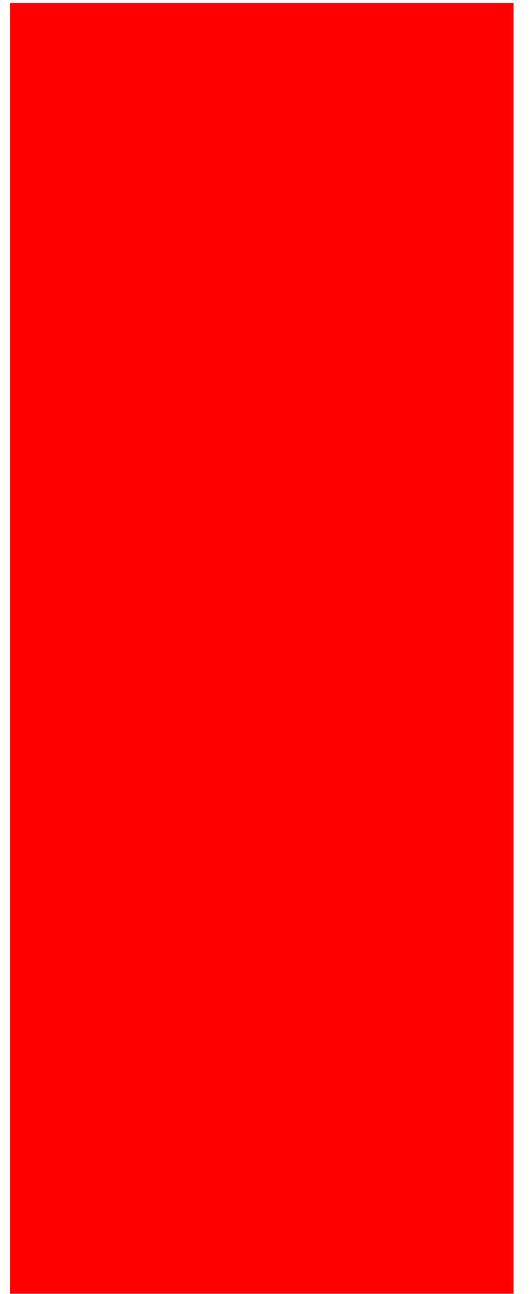
Fiscal Year End	Enrollment	ALTCS Equity	MCP Equity
6/30/08	8,219	\$88.1M	\$117.5M
6/30/09	8,376	\$76.3M	\$124.6M
6/30/10	8,467	\$101.6M	\$178.8M

MCP’s Board of Directors and Finance Committee rigorously govern our financial affairs. MCP also has a substantial team of financial professionals with extensive backgrounds in health care finance and AHCCCS Medicaid management who focus entirely on managing MCP’s financial performance and reporting.

As a not-for-profit company with strong Arizona roots, MCP’s profits are often retained to strengthen MCP or are distributed to our not-for-profit parent companies, Carondelet Health Network Corporation (Ascension Health) and St. Joseph’s Hospital/Catholic Healthcare West (CHW), to reinvest in their local missions in Arizona. This reinvestment philosophy has allowed MCP’s current equity to reach over \$195,000,000 as of January 31, 2011. MCP has no short-term or long-term business loans and is fully self-sufficient. All distributions to parent corporations are made in accordance with AHCCCS standards.

Both MCP and its parent companies are substantial employers in Arizona and are strong community supporters. MCP has more than 1,000 employees dedicated to its operations in Arizona while CHW employs almost 8,700 people in the state. Carondelet Health Network, southern Arizona’s oldest and largest not-for-profit health care provider, employs more than 5,000 people in Pima County alone.

18.





### **Question 18 – Finance and Liability Management**

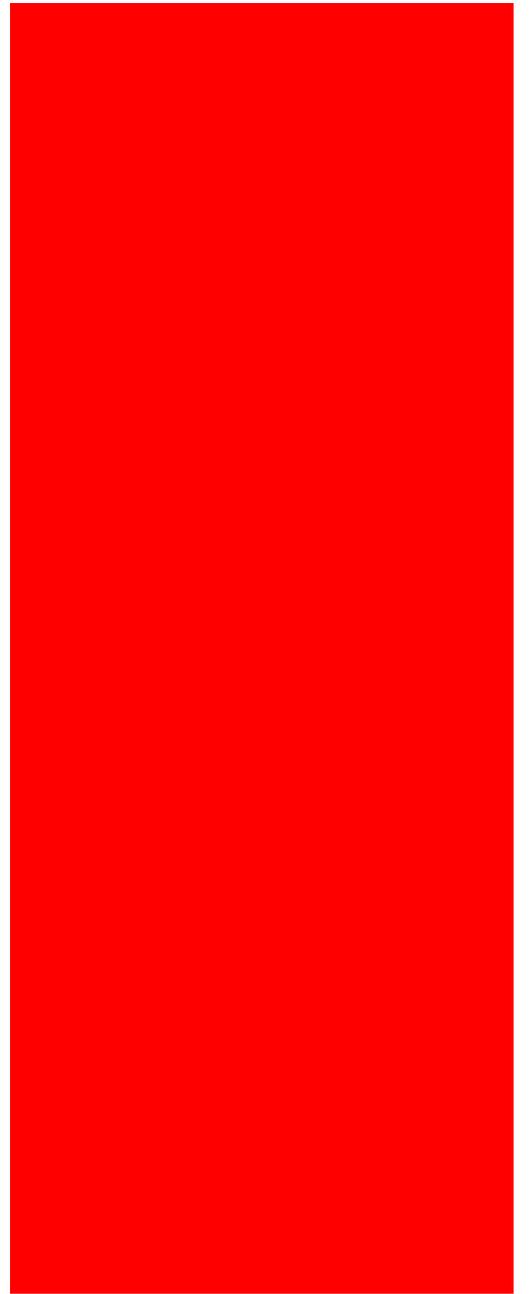
Mercy Care Plan (MCP) currently meets the AHCCCS performance bond requirement through an irrevocable letter of credit in the amount of 80 percent of the total capitation payment that is paid to MCP in the first month of a contract year, or as determined by AHCCCS. MCP's irrevocable letter of credit is collateralized by MCP investments and is with:

JPMorgan Chase Bank, N.A.  
Stand By Letter of Credit Unit  
300 S. Riverside Plaza  
Mail Code IL1-0236  
Chicago, IL 60606-0236

If additional funding is necessary, MCP will increase the amount of the performance bond with JPMorgan Chase accordingly. Funding will be increased within 30 calendar days following notification by AHCCCS. Funding for an increase to the letter of credit will be provided from:

- Operating income
- Investments
- Capital contributions from sponsor organizations, Carondelet Health Network Corporation (Ascension Health) and St. Joseph's Hospital/Catholic Healthcare West (CHW).

19.

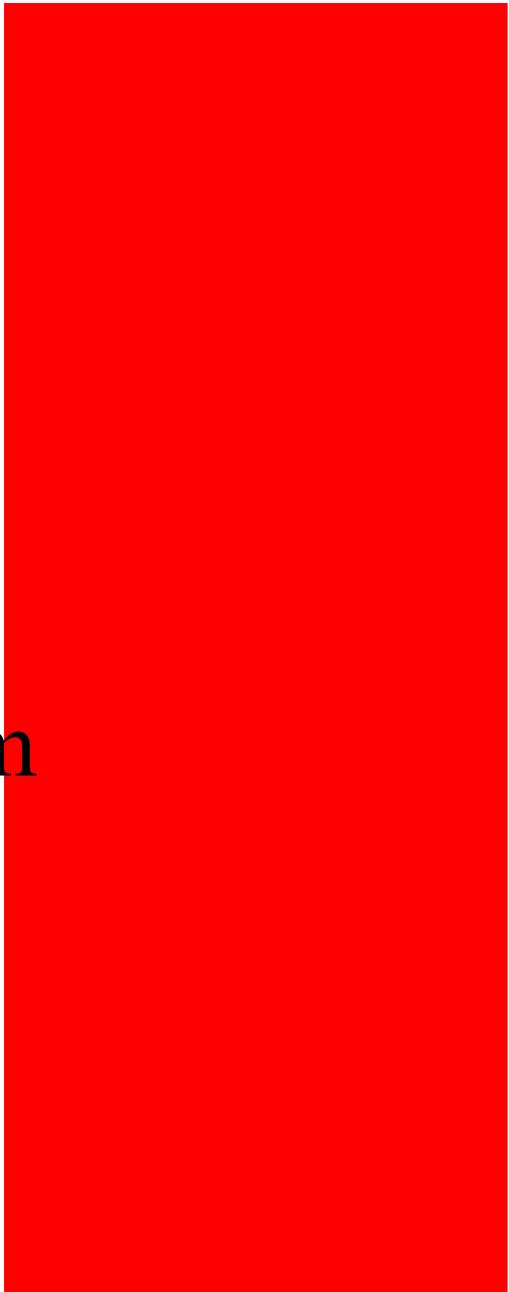




### **Question 19 – Finance and Liability Management**

Mercy Care Plan (MCP) is a contractor in good standing with all AHCCCS financial viability measures. As of 2010, MCP has more than 8,500 ALTCS members. Required equity under the ALTCS contract as of January 31, 2011 is \$17,600,000 for 8,800 members at \$2,000 per member. MCP's actual equity exceeds the required amount by \$75,400,000. Based on the excess equity, MCP will be able to meet the financial viability standard of \$2,000 equity per member for the continuing GSA and the new GSA, effective the first day of the new contract. As of January 31, 2011, MCP's parent companies, Catholic Healthcare West and Carondelet Health Network Corporation, hold over \$195,000,000 of equity at MCP. This substantial equity will allow MCP to meet all minimum capitalization requirements per GSA as described in RFP YH12-0001.

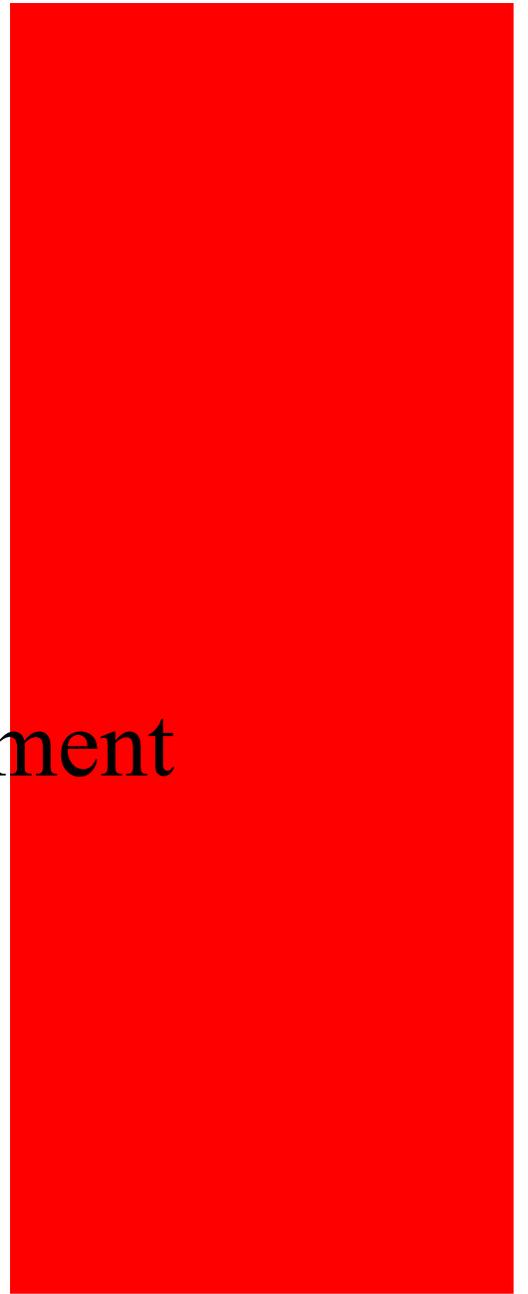
D. Program



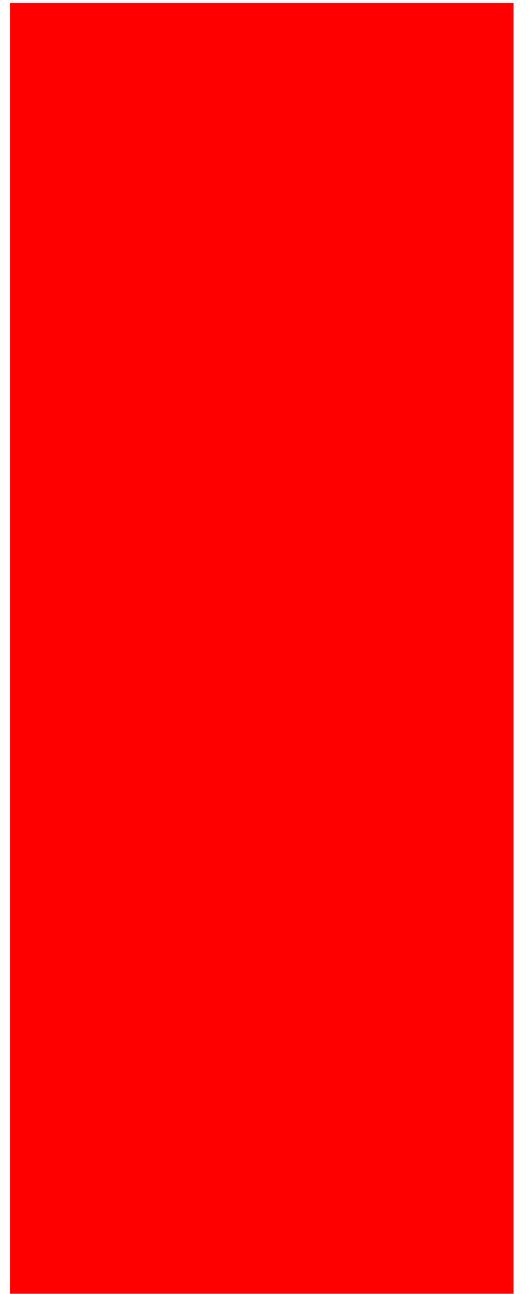
## D. PROGRAM

Table of Contents	
Section	Page #
<b>Case Management</b>	
Question 20	144
Question 21	147
Question 22	150
Question 23	153
Question 24-A	156
Question 24-B	159
Question 24-C	161
Question 24-D	164
<b>Medical Management</b>	
Question 25	166
Question 26	173
Question 27	176
Question 28	179
<b>Quality Management</b>	
Question 29	182
Question 30	185
Question 31-A	188
Question 31-B	191
Question 32	194
Question 33	197
Question 34	200
<b>Oral Presentation</b>	
Question 35	203

# Case Management



20.



## Question 20 – Case Management

Mercy Care Plan’s (MCP) ALTCS members have complex medical and behavioral health needs. Each member’s medical and psychosocial diagnosis, member’s family/caregiver<sup>1</sup> support system, and placement (nursing facility, assisted living, at home) needs are unique. MCP’s holistic case management program is a member-centered service planning and delivery approach with a focus on member choice, improved health/service outcomes, and access to consistent services in the least restrictive setting. This requires the close interaction and coordination within and between our Case Management Department and every other MCP department. MCP’s Case Managers (CMs) are the driving force with the other MCP departments for three key reasons: 1) they have direct access to the member and the member’s family/caregiver and have the greatest understanding of the member’s choices and goals; 2) they provide the interface/connection between the member, our providers (medical, behavioral health, ancillary, long term care, etc.) and low-cost/no-cost community-based supports/services (e.g., dental services); and 3) acting as the member’s advocate, they assure that covered and medically necessary services meet availability, accessibility and quality standards. In our member-centered service planning and delivery model Long term care CMs have five primary roles: a) administration of the often confusing array of services necessary to help the member navigate the complex long term care system and to efficiently make the services/care the member has selected available with the required frequency; b) member empowerment by directly involving the member (and the member’s family/caregiver) in assessment and care planning; c) breaking down barriers to care through member advocacy within MCP, our provider network and with other related health care systems; d) service brokering to coordinate covered, medically necessary services and non-covered community-based services; and e) crisis management to avert events or issues that may cause the member to lose independence and/or move to a more restrictive placement. The best way to illustrate the role of our CMs in coordinating care/services with other MCP departments is in the following graphic:



One of the key advantages of our case management program that supports inter-departmental coordination is the use of our customized case management tracking application-CaseTrakker™ and QNXT™. These applications enable personnel from other departments to review a member’s entire administrative history (enrollment history, contact information, case management assessments and activities, diagnosed conditions, prior authorizations, medication history, lab results when available, discharge planning notes and claims). These tools allow critical member information needed by other departments to be instantly available for decision-making and to support coordination of care. Our medical directors, pharmacists, member services, compliance, utilization management (prior authorization and concurrent review), and quality management personnel have immediate access to member data for management of issues that affect health outcomes, such as: 1) gaps in formal and informal support system; 2) identifying untreated co-morbid conditions, 3) gaps in care, 4) discharge planning with hospital staff, and 5) suspected poly-pharmacy use. If an issue or problem is

<sup>1</sup> Hereinafter, all references to “family/caregiver” include the member’s guardian.

identified, the CM is immediately alerted to take appropriate action, including intervention if appropriate. For example, our P&Ps require our concurrent review nurses to review the member’s information in our data systems to inform a hospital’s discharge planner about the complex issues our member may encounter post discharge.

Our members’ diverse quality of life and placement goals are often complicated by factors related to their age, culture, member’s family/caregiver support and disease state. Our CMs have access to programs developed by other departments, such as QM’s educational programs and health care initiatives (e.g., diabetes management and testing) that will influence a member’s care plan choices and their health outcomes. An important element in the success of inter-departmental coordination to support and influence outcomes from our case management program is our written Policies and Procedures (P&Ps). The P&Ps describe the interdependencies between our departments necessary to promote coordination and communication across disciplines and departments. Our P&Ps are the foundation of our programs and are the source for developing employee training curricula. Through our training programs, we improve inter-departmental coordination by providing employees from all departments with the foundational skills, information, resources, and tools to support our CMs and improve member health outcomes.

Our organizational structure provides the framework for inter-departmental coordination to facilitate our case management program. The goal of improving health outcomes for members is integrated into each of our departments. Through the use of management committees we examine data and develop management approaches to enhance inter-departmental coordination and improve health outcomes. Examples are presented in the following table:

Cross-Functional Committee/Workgroup	Coordination Function	Outcomes
<p><b>Grievance Workgroup</b> Membership includes staff from member services, quality management, case management, network development and contracting, and provider services.</p>	<p>Review of individual member grievances to determine systemic issues impacting member outcomes and develop plans to correct identified problems.</p>	<p><b>Outcome example:</b> In 2009, a DME vendor who was providing poor service was identified; progressive corrective action failed so the vendor’s contract was cancelled, and new vendors were implemented.</p>
<p><b>Quality Improvement Committee</b> Membership includes Chief Operating Officer (COO), Chief Medical Officer (CMO), Vice President (VP) of Long term care (aka Case Mgmt. Administrator/Manager), Quality Management, Medicare, UM, Provider Relations, Member Services and the Director of Prevention and Wellness.</p>	<p>Review of the planning, development, data gathering, testing of interventions and assessment of quality improvement necessary to positively improve outcomes on PIPs identified by AHCCCS and initiatives identified by MCP.</p>	<p><b>Outcome examples:</b> Improved CM processes to positively impact results: 1) Advance directives, in 2010, data analysis revealed statistically significant improvement of 49% over 2009. 2) Influenza vaccination rates increased from 54.8% in 2007 to 80% in 2010.</p>
<p><b>Quality Management/Utilization Management Committee</b> Membership includes CMO, VP of Quality Management, utilization management, long term care, MCP Medical Directors, BH Medical Director, provider services, community providers, and support staff as required.</p>	<p>Review and evaluate the results of quality improvement activities (such as reports, data sets, study results, and general information related to programs, systems, and processes), identify opportunities to improve the care and services provided to members, and recommend solutions to the CMO.</p>	<p><b>Outcome example:</b> Quality of care concerns identified by CM staff were investigated and substantiated by QM/UM Committee. Corrective action plans were implemented and failed, prompting QM/UM Committee recommendation to terminate our contract with the facility. Provider services assisted in identifying alternative contracted facilities for member placements.</p>

Team	Coordination Function	Outcomes
<b>IDT (Interdisciplinary Team)</b> Members include Medical Director, BH Medical Director, BH Coordinator, Concurrent Review VP/manager/supervisor, LTC RN Manager/Supervisor, CMs, Pharmacist.	Review of members who have two or more hospitalizations in past 30 days, repeat hospitalizations in successive months and other criteria in order to develop a plan to deal with the identified issue and improve member health. Selection dependent on ability to impact goal to reduce readmissions.	<b>Outcome examples:</b> Typically there are three outcomes from an IDT intervention that affect a member's health outcomes: 1) the CM has additional care planning options; 2) improved coordination of care between the member, the member's family/caregiver, PCP, and specialist; and 3) reduced medically unnecessary hospital and ED utilization.
<b>Provider Services-Long Term Care Team -</b> Members include staff from: Case management, provider services, and network development.	CMs identify and network development resolves gaps in MCP's provider network relative to ALTCS covered services. Provider identified issues (e.g., claims payment, contract implementation) are discussed and plans for resolution are developed.	<b>Outcome example:</b> In 2010 this committee suggested contracting with 12 new assisted living facilities that LTC case management had identified as being necessary to meet member's needs.
<b>Challenging Member Team</b> Members include staff from: CM, Compliance, Provider Services, Member Services, and BH Department.	Identification of individual members who have challenging needs due to the complexity of care or co-morbid BH issues; development of a plan to meet member needs.	<b>Outcome example:</b> Identified single point of contact for member, member's family/caregiver and other MCP departments for communication of challenges to health plan as well as support/resolution of concerns.

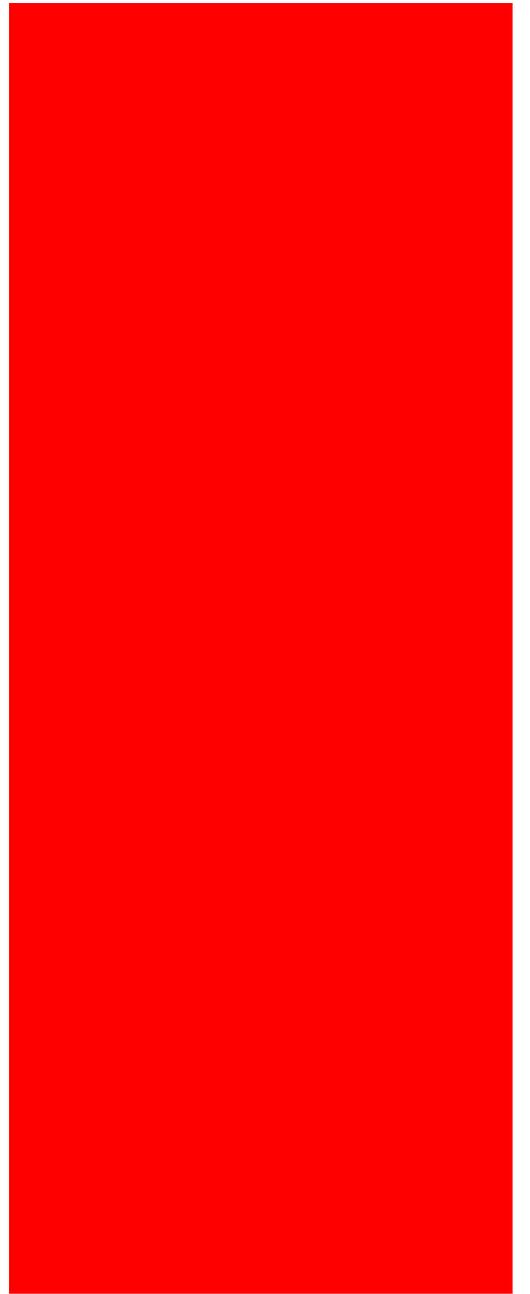
## Case Study

MCP's CEO and CMO have and continue to embrace improving diabetic management and screening performance as a critical way to enhance health outcomes for our members. Diabetes screening and management (hereinafter referred to as DS&M) became a health plan priority and resources were allocated to develop and implement a comprehensive performance plan to improve compliance with evidence based practice guidelines. The CMO delegated responsibility to the VP of Quality Management (VP of QM aka Quality Management Coordinator) to lead the effort in improving diabetic management and screening. Leading this initiative involved the engagement, participation, and coordination of all MCP departments, members, members' families/caregivers, and providers. Based on direction from MCP's CMO, and input from members, members' families/caregivers, and providers, the VP of QM developed a strategy that was multi-disciplinary, inter-departmental, and included: 1) identifying ALTCS members with service gaps related to DS&M; 2) identifying the member's PCP; 3) identifying the member's CM; 4) implementing the interventions necessary to improve compliance with DS&M. Interventions taken by CMs include encouraging members to see their PCPs regarding DS&M and requesting documentation from the PCP that DS&M was completed. Reporting to our Quality Management/Utilization Management (QM/UM) Committee, the Quality Improvement Committee (QIC) is instrumental in identifying member and provider interventions based on root cause analysis. The strategy for improving DS&M results was developed through our QIC, chaired by our CMO, with department leaders from a) CM, b) quality management, c) network development/provider services, d) member services, and e) medical management. Following the Board's vision, QIC applied protocols to develop, evaluate, and monitor our approaches for improving compliance with evidence based clinical practice guidelines on DS&M. Presented in the table below is a summary result of our performance:

**Summary of MCP's Diabetes Screening Performance 2006 - 2009**

Measure	2006	2007	2008	2009	ALTCS Statewide Avg	ALTCS Goal
Diabetes HbA1C rate	82.2%	87.3%	88.7%	90%	86.6%	89%
Diabetes LDL-C testing	80.6%	82.8%	85.7%	88%	77.9%	91%
Retinal eye exam	52.3%	67.5%	68.2%	75.4%	63.9%	68%

21.



## Question 21 – Case Management

Since 2000, Mercy Care Plan (MCP) has provided a high-quality case management program to assess, identify and meet our member's needs. We tailored our case management program to meet the needs of our elderly and physically disabled ALTCS members based on their place of residence (nursing facility, assisted living or HCBS), and complexity of needs (behavioral health and complexity care needs). This program design increases consistency in assessing our members' needs and providing service authorizations because our Case Manager (CM) specializes in a type of residence or member's care needs. Our electronic case management program, CaseTrakker™ also increases consistency in CM activities because many of the required case management forms, protocols and requirements are incorporated into the application and edit features prevent oversights, omissions or errors. Another key element for consistency of assessment and service authorization for HCBS members is our training program. During training a new CM is assigned a mentor, completes two weeks of fieldwork orientation and then three weeks of classroom training before incrementally being assigned a caseload. CMs are empowered to authorize HCBS services that are included in the members care plan. Our case management program includes a management system to monitor the provision of consistent, appropriate, and quality CM services. The Case Management Administrator/Manager, reporting to the COO, is responsible for oversight of our ALTCS program, including but not limited to, the design, implementation, management, direction and execution of our CM program. All CM activities, including assessment, care planning, service determination and service authorization, are monitored by a manager and supervisor. We designed our case management Policies and Procedures (P&Ps), management/supervision structure, and protocols for maximum consistency in member assessment and authorization of HCBS services. MCP's quarterly system of internally monitoring HCBS member assessment and service authorizations includes: 1) supervisor case reviews; 2) report audits; 3) standardized chart audits; and 4) inter-rater reliability. Results from this monitoring, including our continuous process improvement strategy of Plan-Do-Study-Act (PDSA) to address identified inconsistencies or deficiencies are documented and available to AHCCCS upon request. Each of these components is described below.

### Supervisory Case Reviews

Each CM Supervisor is responsible for the direct supervision of HCBS case management. The purpose of the supervisor case reviews is to validate adherence to case management P&Ps. Elements that trigger a case review include: 1) if the member has recently become eligible or changed to an HCBS setting; 2) any other changes noted in the member's record (e.g., recent emergency room activity, discharge from a hospital admission, change in diagnosis, etc); 3) issues observed in previous audits or case reviews; 4) the CM's "time in service" and observations from the CM's mentor; 5) member or provider complaints or grievances; and 6) recommendations from the member's family/caregiver<sup>1</sup> and/or PCP. These reviews occur on a daily basis according to the triggering event. The supervisor case reviews follow a set format and test if the CM activities have been consistent with case management P&Ps and the case management standards set in the AHCCCS Medical Policy Manual (AMPM). One hundred percent of cases assigned to new CMs are reviewed by their supervisor for the first 90 calendar days.

### Audit Reports

On a monthly basis, or as needed, each supervisor runs standardized audit reports on CM's activities from our automated case management system (CaseTrakker™). These audit reports profile a CM's activities, compliance with timeframes, adherence to P&Ps and completeness of work. System audit reports are run each month on or about the same day. The purpose of these auditing reports is to analyze, monitor and identify a CM's compliance with P&Ps and AMPM standards. Audit reports are designed to specifically track and trend various activities for compliance. The supervisor records the results of each audit, tracks and trends inconsistencies, omissions and errors, reports results to the manager and identifies if additional training is needed for the individual CM or the case management team. Our HCBS CM supervisor has 83 case management compliance reports available for review. Each compliance report measures a specific case management activity.

---

<sup>1</sup> Hereinafter, all references to "family/caregiver" include the member's guardian.

A sample of audit reports includes:

• Assessment Status Report	• LTC Placement Members in Transitional Status
• Attendant Care Hour Average	• New Member Compliance Check
• Behavioral Health Events Not Completed	• Overdue Authorizations
• CES Compliance Check	• Placement and Service Conflicts
• Data Entry Time Check	• Productivity Report
• Initial Assessment Data Check	• Duplication of Service Report

### Chart Audits

Each supervisor completes a minimum of two monthly chart audits, per CM. The supervisor uses a standardized internal audit tool to capture critical case management program elements that we are unable to quantify in a case management compliance audit report (see above) – such as quality and detail of progress notes or assessments. After chart audits are completed the supervisor meets with each CM to review audit findings. These sessions are designed to reinforce our P&Ps and AMPM standards. Issues discussed at these meetings may include, but are not limited to: identification of deficiencies and establishment of timelines for follow-up action, discussion of treatment barriers and recommendations and re-education or re-training plans. At the end of each quarter, the manager runs a report of chart audit results completed during the quarter. These results are compared to the results from the previous quarter and a corrective action plan is developed by the supervisor (in conjunction with the manager) if there is a pattern of scoring below 90% for auditable events or activities. Corrective action plans are shared with Case Management Supervisors and CMs. Corrective action plans may include: staff re-training, process revision, or counseling of individual staff members.

### Tracking of Audit Results

The supervisor enters the results of the chart audits into our automated case management system – CaseTrakker™. This allows all results to be compiled, analyzed, trended, and reported. Standards reviewed during these audit processes are described in section 1600 (i.e., Section 1620: Case Management Standards) of the AMPM and may include, but are not limited to evaluation of: a) CM time frames (see AMPM Exhibit 1620-1); b) completeness, timeliness and accuracy of required case management forms (e.g., ALTCS Member Change Report, AHCCCS/ALTCS Uniform Assessment Tool); c) needs assessment/care planning; d) cost effectiveness study; e) case file documentation; f) record/report of abuse/neglect/exploitation and g) placement/service planning. Any inconsistencies, omissions or errors are documented by the supervisor for discussion with the CM at the next meeting or if urgent issues are identified as soon as possible. The supervisor records the results of each audit, tracks and trends inconsistencies, omissions and errors, reports results to the manager and identifies if additional training is needed for the individual CM or the case management team. CMs who continually fail to exhibit performance lower than required or expected will either: i) attend additional training; ii) have their case load reduced; iii) develop a corrective action plan; or iv) be subject to personnel action including, but not limited to transfer out of case management, suspension or termination.

### Case Management Inter-Rater Reliability

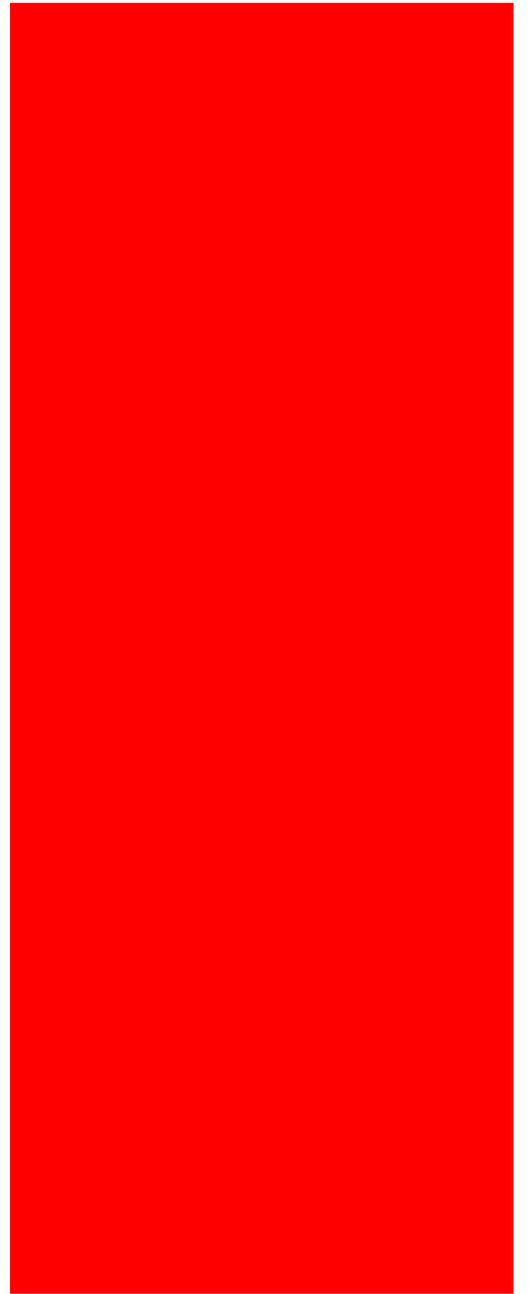
Our Inter-Rater Reliability (IRR) protocols were designed internally and approved by AHCCCS' ALTCS Division of Healthcare Management. Our best practice approach to the peer review process is continuously applied throughout the year. Each CM participates in the program at least once per year as a *CM observer* and as the *observed CM* (the CM being assessed). The purpose of IRR is to monitor the level of consistency between CMs in assessment and service authorization decisions when evaluating the same member. Elements reviewed for consistency include assessment of the member's 1) attendant care hours needs, 2) levels of care, 3) activities of daily living needs, and 4) independent living skills. For internal consistency and accuracy HCBS CMs are only paired with other HCBS CMs. Since specialty behavioral health and complex care CMs are responsible for members in a HCBS setting they are also paired and participate in this IRR review. During IRR peer reviews, CMs use the following: 1) Uniform Assessment tool, 2) LTC Assessment tool, 3) Attendant Care Worksheet, 4) Spouse Attendant Care Worksheet, and 5) IRR Observation Form. The assigned CM (aka *observed CM*) conducts the assessment, and completes assessment tools as usual; the *observing CM* also completes the tools. Both CMs attend the member's in-home assessment together, but the *observing CM* does not intervene or interject. The *observed* and the *observing CMs* neither collaborate nor discuss results during or after the assessment. Following the assessment, CMs turn in their completed tools to the *observed CM's* supervisor for review. The supervisor compares and contrasts the assessment and service authorization results. Following supervisor review,

both CMs meet with the supervisor to discuss any inconsistencies identified regarding the member's needs assessment, level of care determination and services authorized. Education and coaching is a critical element of this session. The supervisor records the IRR review results in the IRR Tracking Sheet. The designated supervisor produces a quarterly report of these results for review, analysis, and trending. These quarterly reports are analyzed and results from each quarter are compared to the previous quarter; outcomes are available to AHCCCS upon request.

### **Continuous Process Improvement**

We use the PDSA method to analyze and apply the results of our auditing and IRR processes to improve consistency of HCBS CM assessment and service authorization process. CM Supervisors and Managers analyze the results of each quarter's audits and IRR to identify areas where improvements are needed and if additional training is required or if case management training/P&Ps need revision. Our Case Management Managers and Supervisor will develop a process improvement plan and present the plan to the Director of Case Management. After review and approval by the Director the Process Improvement plan is presented to the QM/UM Committee for final approval. Examples of process improvements to increase consistency of assessment and service authorization as a result of these activities include: 1) Analysis of audit report data identified the potential over or under utilization of attendant hours. CMs are now required to review attendant care increases and any members who have greater than 20 hours per week with their supervisors; 2) Review of audit report data identified authorization of duplicative services such as attendant care and home delivered meals or assisted living and adult day health care. This information was used to identify CMs who need retraining on the appropriate authorization of HCBS covered services; 3) In 2010, based on chart audit results we initiated a program to re-train CMs to improve their understanding of assessment and documentation requirements. Following re-training, CMs were trained on participating in a peer audit project that included using a chart audit tool to review two of their peer's cases. Results were reviewed by the CM's supervisor and then discussed with the CM. CMs found this activity to be a positive educational experience; 4) Implemented an electronic CM file using the CaseTrakker™ system to include documents previously stored as hard copies. This provides uniform access to the member's case management file for program personnel.

22.



## Question 22 – Case Management

Mercy Care Plan's (MCP) Case Management program has been working with ALTCS complex care members since 2000. We have been continuously enhancing the Case Management program to meet the needs of our complex care members. As a result, in 2004 MCP established two specialty teams – high risk behavioral health (BH team) and Medically Complex Care team (MCCT) - to serve members with the most severe behavioral and complex care issues. The Case Management Administrator/Manager, reporting to the Chief Operating Officer (COO) and in consultation with the Chief Medical Officer (CMO), is responsible for oversight of the complex care members. All Case Managers (CMs) on the BH Team have behavioral health related masters degrees and all CMs on the MCCT are RNs. Due to the complexity and challenges presented by members with complex BH and medical needs, CMs on these teams have a case load lower than the AHCCCS required standard (AMPM, Chapter 1600). For example, a CM on the MCCT may have a case load of 1:32 rather than a usual caseload of 1:48. Policies and Procedures (P&Ps) for the specialty teams govern activities and protocols that are consistent with AHCCCS regulations (AMPM, Chapter 1600). In our member-centered service planning and delivery model, special team CMs have six primary roles: 1) assisting the member to navigate the complex long term care system and often confusing array of services; 2) maximizing member empowerment through assessment and directly involving the member and member's family/caregiver<sup>1</sup> in the care planning process; 3) utilizing member advocacy to avoid barriers to care; 4) service brokering to coordinate covered, medically necessary services; 5) coordinating community-based services with other involved entities (e.g., Adult Protective Services, Child Protective Services, County Office of the Public Fiduciary, Ombudsman, Children's Rehabilitative Services (CRS), etc.); and 6) providing crisis management to avert events or issues that may cause the member to lose independence and move to a more restrictive placement.

The delivery of specialized case management helps improve the member's quality of life for members with multiple co-morbidities, complex behavioral, substance abuse and medical issues, and a history of high ED or hospital use that complicates their care and increases utilization. Members assigned to one of the complex care teams are identified in a variety of ways: 1) review of the PAS at the time of enrollment, 2) referrals from general<sup>2</sup> CMs and/or the Medical Management Department (e.g., quality management, prior authorization, and/or discharge planning), 3) recommendations from Inter-Disciplinary Team (IDT)<sup>3</sup> meetings, 4) review of our monthly proprietary predictive modeling report that identifies members at the highest risk for hospitalization or an ED visit.

Within 10 days of assignment, members assigned to a specialty team receive a new in-home assessment from their specialized CM. This assessment begins with the member's care plan and provides an opportunity for a comprehensive review of the member's complex medical and behavioral health needs to develop a new specialized care plan. The MCP behavioral health medical director and our other medical directors are consulted as appropriate in the development of effective strategies for service planning to meet the needs of the complex members. As part of our assessment, the CM will contact the member's PCP and specialty providers to gather additional information necessary to complete the member's specialized care plan.

We use a holistic member-centered approach to develop the member's specialized care plan. The CM works closely with the member and the member's family/caregiver to determine the member's goals as well as to identify their individual strengths and challenges. Often, these members have a difficult time identifying and internalizing these service goals. Through the use of member engagement strategies, such as motivational interviewing, the CM reinforces physicians' orders, educates the member and member's family/caregiver to improve health literacy, and encourage the member and the member's family/caregiver participation in the management of their conditions.

Should issues in developing the specialized care plan arise that require multi-disciplinary support, MCP has a forum for this collaboration through our weekly Inter-Disciplinary Team (IDT) meetings. The IDT meetings involve a detailed review of the member's case and needs with an emphasis on providing the CM with care planning strategies. In preparation for the IDT, the CM will contact the PCP, specialists, and other involved entities to gather additional information and recommendations to consider during the IDT meeting, including the member's behavioral health/medical history. The IDT consists of the behavioral health medical director and medical directors, vice president of utilization management, a pharmacist, Long Term Care RN manager/supervisor of our MCCT, behavioral health coordinator,

---

1 Hereinafter, all references to "family/caregiver" include the member's guardian.

2 Our general CMs are assigned a case load based on the member's placement in either a home setting, Assisted Living Facilities, or Nursing Homes. Additionally, certain general Case Managers are assigned pediatric cases or members with limited English speaking skills.

3 See discussion on the next page.



member's assigned CM, as well as invited program personnel including but not limited to: Concurrent Review Nurses, Post-Discharge CMs, Long Term Care Managers, and Provider Services Managers.

The recommendations from the IDT support our CMs in three different ways: 1) the CM has additional care planning options; 2) improved coordination of care between the member, the member's family/caregiver, PCP, and specialist; and 3) reduced medically unnecessary hospital and ED utilization. Often, a medical director (BH or medical) personally communicates with the member's PCP or specialist to discuss care plan strategies.

### **High Risk Behavioral Health (BH) Team**

MCP defines behaviorally complex members as those members who usually have a Serious Mental Illness (SMI) diagnosis in conjunction with Elderly and Physically Disabled (EPD) issues and utilize a specialized provider network, including behavioral health settings. Members may also have a Traumatic Brain Injury (TBI), dementia, or a cognitive disability. Members may require court-ordered treatment, considered to be at risk to self or others, have multiple psychiatric inpatient admissions (including, but not limited to, Arizona State Hospital), transition from a Regional Behavioral Health Authority (RBHA), or have current placement in a specialized BH setting. Due to these special complex care needs, these members are assigned to MCP's BH CMs for optimal case management and service coordination.

MCP has a robust BH team (consisting of a BH Medical Director, two (2) BH managers, a BH supervisor, 12 dedicated BH CMs, two (2) BH Specialists, and a BH Coordinator) who serves those members with profound BH needs. In addition, the BH team consults with and supports the member, member's family/caregiver, providers, and other MCP departments (e.g., Concurrent Review, Quality Management, Member Services, Network Development, Provider Relations, Prior Authorization), in navigating the complexities of BH placement, treatment, and interventions. In collaboration with the two (2) BH managers, MCP's BH medical director, who is board certified in both psychiatry and addiction psychiatry, leads the BH team. The BH Medical Director provides clinical consultation in order to: 1) review inpatient admissions and discharges for medical necessity, 2) review pharmacy utilization, 3) complete clinical consultation with internal staff, 4) provide clinical education to contracted providers, 5) promote quality initiatives, and 6) review court documents for compliance with judicial clinical requirements.

MCP has recognized the need to preserve a member's placement in a non-behavioral health setting. Under the direction of the BH team, MCP is implementing the Consultation and Clinical Intervention (CCI) program, in conjunction with Community Partnership of Southern Arizona (CPSA). The purpose of the CCI program is to support members who are residing in a non-behavioral setting and who are exhibiting behavioral issues that are jeopardizing their current placement. The CCI program will complete a timely and comprehensive functional analysis and develop a behavioral management plan for members who are at risk of losing their non-behavioral health placement. The member's comprehensive functional analysis and behavioral plan is incorporated by the CM into the member's care plan. The revised care plan is shared with the member, the member's family/caregiver, the member's PCP/specialist, and other involved entities.

### **Medically Complex Care Team (MCCT)**

MCP identifies members to be assigned to the MCCT due to their complex chronic care needs. Often these members have a history of frequent hospitalizations, frequent ED use, and failure to comply with PCP orders for their disease states. In addition, members are identified for management by the MCCT if they are: 1) residing in the community/assisted living facilities and: a) are ventilator dependent; b) have a tracheostomy; c) have had multiple hospitalizations; d) have severe skin break-down; or e) have other issues that place them medically at risk for hospitalization; or 2) residing in a nursing facility and are: a) ventilator dependent; b); have a tracheostomy; or c) on staff assist dialysis. Due to these special complex care needs, these members are assigned to MCP RN CMs for optimal case management and service coordination.

Our MCCT consists of an RN Manager, an RN Supervisor, and six (6) dedicated RN CMs; with support from our BH Medical Director and Physical Health Medical Directors. Utilizing their medical expertise and training, our RN CMs determine the most appropriate level of care necessary to meet the member's medical and long term care needs. Additionally, our RN CMs: 1) review medications to determine adherence and relay this information to the member's PCP; 2) review specialty DME needs, 3) review complex medical supply needs, 4) coordinate care with home health agencies, 5) coordinate PCP and specialist appointments, and 6) provide disease specific education and self-management techniques to the member, or member's family/caregiver. When a member assigned to the MCCT is hospitalized, the RN CM uses a collaborative approach to work with the member, member's family/caregiver, the MCP concurrent review nurse, the member's PCP and specialist(s), the hospital's CM/discharge planner, other involved entities, and MCP's post discharge CM, when appropriate. This is a very similar process that is used by our general CMs; however, for members

assigned to the MCCT, there is often a complex array of issues and multiple providers requiring coordination and management.

### **Coordination of Providers and Involved Entities**

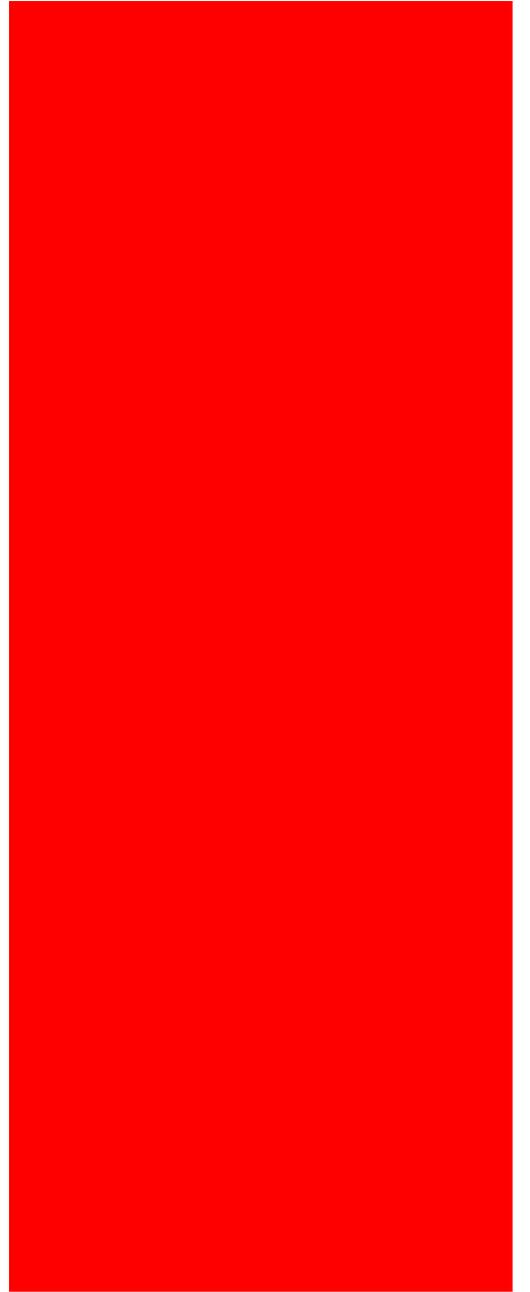
Members with the most complex medical and BH needs often require treatment from multiple providers and coordination with other involved entities. In many instances these providers and other involved entities work independent of each other. This may increase risk for: 1) adverse drug reactions, 2) duplication of services, 3) avoidable ED visits or hospitalizations, or 4) member confusion regarding conflicting care plans. Our BH Team and MCCT have the training and experience to intervene on behalf of the member to improve coordination between providers and involved entities. Our BH and MCCT CMs focus on keeping the member's PCP and other specialists up-to-date on the status of the member's care plan and any changes in the member's condition. Care coordination support examples include: 1) obtaining and sharing pertinent medical and BH medical records with the PCP, specialist, other providers actively providing services; 2) following up with providers regarding medical records that were shared to coordinate changes in member care plans; 3) informing PCPs, specialists, and other providers of the member's most recent pharmacy fill history; 4) facilitating safe transitions (e.g., from hospital to home, from nursing facility to home, from the Regional Behavioral Health Authority (RBHA) to MCP) to maximize consistency of services and improve continuity of care; 5) advocating on behalf of the member to improve accessibility of services, collaborate with stakeholders, and facilitate with involved entities on approaches to maximize the member's care plan; and 6) collaborating with CRS in order to meet the member's needs and avoid gaps in care.

MCP actively supports our members in coordination with other involved entities. For example, this support includes, but is not limited to, providing exchange of information (as requested) with the County's Office of the Public Fiduciary, Area Agency on Aging Ombudsman, and Officers of the Court. The purpose of these activities is to provide for the effective and efficient transfer of information regarding the member's care plan.

### **Additional Support for Case Managers**

MCP's general CMs manage members with BH and medical care needs on a daily basis. In certain circumstances, the member's needs escalate, prompting the general CM to seek consultative assistance from a BH or MCCT CM. In these instances, the BH and MCCT CM becomes a resource for the general CM and promotes coordination of the member's care. The role of the BH and MCCT CM may include, but is not limited to: 1) a telephone consultation with the general CM, 2) quarterly BH consultations, 3) review and interpretation of behavioral or medical documentation from the member's provider(s), 4) participation in a joint home visit with the general CM, 5) providing recommendations and educating the CM, the member, and the member's family/caregiver of the care plan, and 6) acting as a liaison between the MCP medical director/medical management and the member's assigned CM. Additionally, general CMs have access to medical directors for consultation when a higher level of expertise is required.

23.



## **Question 23 – Case Management**

Since 2000, Mercy Care Plan (MCP) has successfully implemented and evolved a member-centered assessment and care planning process. MCP's Case Management Administrator/Manager, reporting to the Chief Operating Officer (COO) and in consultation with the Chief Medical Officer (CMO), is the executive leaders with authority and responsibility to administer the process for assessment and care planning services. Our Long Term Care (LTC) workgroup, reporting to the Case Management Administrator/Manager, consists of five (5) LTC Managers, 13 LTC Supervisors, and 157 LTC Case Managers<sup>1</sup>. MCP has developed a standardized, comprehensive case management training program that provides Case Managers (CMs) with consistent and robust training to gain knowledge and experience in the assessment and care planning for members with home-based services. Our case management process is based upon respect for the member's preferences, interests, needs, culture, language, and belief system. The foundation of MCP's Case Management program is to effectively assess and develop holistic and member-centered care plans. As a result of our program focus on keeping members in the least restrictive setting, three-quarters (75%) of our overall membership are residing in the community. It is important to recognize that 86 percent of these members are living in a private home.

### **Assessment Processes for Home-Based Services**

Our CM builds a relationship of trust with the member to perform a member-centered holistic assessment. Our assessment strategy supports maximum member self-determination and member's family/caregiver<sup>2</sup> involvement. We begin with a respect for the member and member's family/caregiver's preferences, interests, needs, culture, language and belief system. MCP assigns CMs based on: 1) the member's placement type (with CMs dedicated to HCBS, assisted living, and nursing facility placements); and 2) member's complex and special care needs (e.g., Behavioral Health (BH), medically complex, and pediatric members).

Upon notification of enrollment, the intake coordinator reviews the Pre-Admission Screening (PAS) and assigns the appropriate CM. If necessary, the member's case may be referred for a second level review by a LTC manager to determine if there are BH and/or medically complex needs that would require assignment to a specialized CM.

It is MCP's experience that making the initial contact with the member within five business days, rather than the seven business day AHCCCS standard, enables us to expeditiously initiate the intake process. Our intake process begins with the scheduling of the initial assessment at the member's place of residence within 12 business days after enrollment. During this contact, the CM also works with the member or the member's family/caregiver to identify any needed translation services and resolve immediate issues. These immediate issues often include acute medical concerns, pharmacy needs, or placement issues. The CM also determines, based upon members' desires, if the members' families/caregivers should be involved in the initial assessment interview. A tenet of our case management processes is to include the member's support system; however, we always respect the member's preferences in the process. At the end of this initial contact, the CM sends a welcome letter to the member confirming the CM contact information and agreed upon date and time of the scheduled intake appointment.

Our CM conducts the initial assessment interview in the member's residence. As part of this interview, the CM explains to the member and the member's family/caregiver<sup>1</sup> the role of the CM in: 1) needs assessment, service planning, and coordination, 2) brokering of services to maximize the effectiveness of the service plan, 3) facilitating and advocating on the member's behalf for covered and non-covered community-based services, 4) ongoing monitoring and reassessment of the member's needs, 5) gatekeeping through assessment of needs, including determination of ALTCS services cost effectiveness, and 6) identifying and coordinating benefits (e.g., Medicare, Children's Rehabilitative Services (CRS)) and Third Party Liability (TPL). During the in-home interview, the CM conducts an assessment of the member's medical condition(s), functional, and psycho-social needs. In performing this member-centered assessment and care planning the CM applies their training, experience, and knowledge to identify and respond to the member's preferences, interests, needs, language, culture, and belief systems.

During an initial assessment, the CM gives and reviews with the member and the member's family/caregiver a new member packet. This packet includes a: a) member handbook, b) provider directory including a zip code specific urgent care listing, c) information on HIPAA, d) member rights and responsibilities acknowledgement, e) Critical Service Gap Report Form, f) self-directed attendant care pamphlet, g) advance directives form, and h) CM/transportation contact information magnet. The CM also thoroughly reviews items from the Member Handbook such as: the entire spectrum of LTC services, behavioral health crisis line, no-cost translation and transportation services, and instructions on how to file

---

<sup>1</sup> 139 general Case Managers, 12 BH Case Managers, and 6 Medically Complex Care Team (MCCT) RN Case Managers

<sup>2</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

a grievance or appeal. Members are asked to sign a member packet acknowledgement form indicating they have received all the information described above, that items have been reviewed, and that they understand what has been received. The CM advises the member of the name and contact information of their assigned PCP and how to request a change of their PCP assignment. The member is also made aware of our Patient Centered Medical Home (PCMH) program that serves members through “in-home” visits at the member’s placement (NF ALF or the member’s home) that is part of the PCP choice options. During the initial assessment process, the CM asks the member and the member’s family/caregiver the member’s goals and desires for placement and services. The CM summarizes the member’s goals, BH and unmet needs in the assessment.

MCP has continually revised and improved its standardized Assessment Tool to effectively capture our members’ strengths and needs to facilitate design of the member-centered care plan. Our LTC management team modifies our Assessment Tool so that it remains responsive to changes in AHCCCS requirements. Our Assessment Tool was developed with the goal of assisting the member and the member’s family/caregiver and the CM to recognize: 1) the member’s strengths and needs; 2) cultural considerations; 3) the member’s capacity to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL); 4) the potential need for behavioral health services; 5) formal and informal support system; 6) the need for Durable Medical Equipment (DME); 7) current living situation; 8) if the member has and is attending scheduled appointments with their PCP/specialist; 9) history of recent hospitalizations or ED use; 10) current medication and medical conditions; 11) members’ self-reported level of pain; 12) the member’s need for a specialty diet and their adherence to it; 13) any reported incidents of neglect, abuse or exploitation; and 14) preferred contact information.

Due to the high risk of development of pressure ulcers and risk of falling, for our ALTCS members, especially those who reside in their own homes, MCP proactively developed a unique Assessment Tool, Skin and Fall Evaluation (SAFE). Our SAFE tool is divided into two sections. The first section addresses members at risk for skin breakdown based on factors such as incontinence and immobility. Members identified as being at risk for skin breakdown are offered an RN visit as part of their care plan. If the RN identifies a need for treatment, the CM will coordinate care with the member’s primary care provider (PCP) and request/authorize services. The second section of the SAFE tool addresses a member’s risk of falling. If the CM determines the member is at risk of falling, the CM uses the Center for Disease Control (CDC) fall prevention brochure/checklist. The checklist allows the CM to identify hazards in the member’s home that could cause a fall. The CM reviews the brochure with the member and the member’s family/caregiver. The brochure describes how to provide a safe environment and prevent falling. The CM will identify if the member is on any medications that could increase the risk of falling and notify the PCP.

The CM enters the assessment into our proprietary case management data system, CaseTrakker™. Once the CM enters the assessment into CaseTrakker™ it is readily available and accessible by any CM or supervisor. This also makes the assessment available to utilization management staff (utilization review, concurrent review, and retrospective review) for medical decision-making. Furthermore, entry of the assessment into CaseTrakker™ automatically notifies the CM to schedule the reassessment within 90 calendar days.

## **Care Plan Development**

In a shared partnership with the member and the member’s family/caregiver, the CM facilitates development of a member-centered care plan. An important element of MCP’s case management program is the emphasis on a trusting relationship between the CM and the member and the member’s family/caregiver to facilitate identification of member’s goals, strengths, needs, and challenges. Our CM begins building the care plan based on the outcome of the holistic assessment, reviews the PAS and recommendations from the member’s PCP and other care providers. Key to the care plan development is the involvement of the member and the member’s family/caregiver in the identification of member-centered goals (e.g., improve self-sufficiency in areas of housing, education, and employment). In order for the member to make an informed choice, the CM provides the member and the member’s family/caregiver information relative to the continuum of ALTCS services, and community resources available to meet the member’s goals/needs. The CM synthesizes the results of assessments, input from the member’s PCP and other providers, observation of the member’s environment, and consideration of the member’s culture and values to develop the care plan.

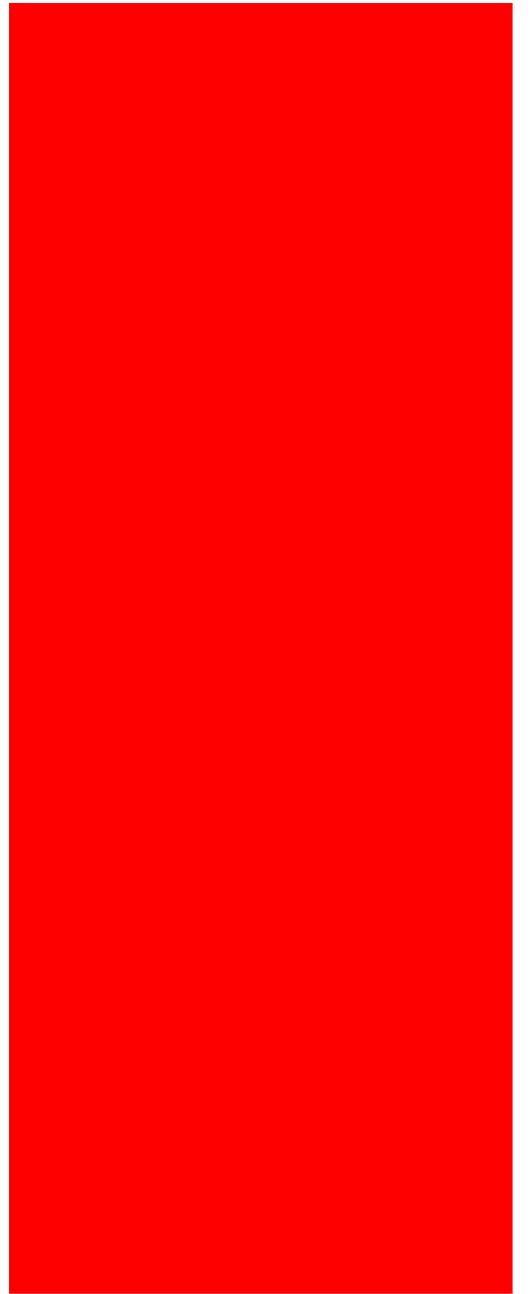
The purposes of the care plan are to provide: 1) the member and the member’s family/caregiver with a clear understanding of their goals and agreement of the selected service options; and 2) a summary of the member’s rights and responsibilities including contact information as well as their grievance and appeals rights; 3) a point-of-reference to all MCP personnel to facilitate coordination of members’ care. The care plan is a valuable resource for the member because it indicates the member’s rights and responsibilities including their grievance and appeals rights and the agreed to services, who the

provider of care will be, and when the services are scheduled to occur (including scope, duration, intensity of each service). When the assessment and care plan development process is completed and before the CM leaves the home, a copy of the member's signed care plan is provided to the member or the member's family/care giver. The care plan is available in CaseTrakker™ for utilization management – prior authorization, concurrent review, quality management, and compliance personnel – to use in decision making. This is a powerful resource for MCP personnel to support the member's care plan and goals.

Once the member has made his/her service choices on the care plan the CM completes AHCCCS' Cost Effectiveness Study (CES) and Uniform Assessment Tool (UAT) with the member and the member's family/caregiver. The purpose of using the CES is to determine if the chosen services can be provided in a cost effective manner. The CM specifically educates the member and the member's family/caregiver of how and to whom the member and member's family/caregiver are to report unavailability of critical services. If the care plan includes attendant care (general attendant, family attendant, self-directed, skilled self-directed, and spousal attendant care), personal care, homemaker services, or respite care, the CM develops a Contingency Plan. The CM works with the member and the member's family/caregiver to develop an understanding on how to use the Contingency Plan and leaves a copy with the member.

MCP's assessment and care plan development is an ongoing and fluid process between the member and the member's family/caregiver and CM. A new assessment is conducted and care plan developed at least every 90 calendar days and more frequently in the event there is a change in the member's condition or upon member or the member's family/caregiver request. MCP values the assessment and care planning process because it is member-centered, leads to consistency of services, provides for care in the most integrated setting and promotes positive health outcomes for our members.

24-A



## **Question 24 – Case Management**

### **A. Oscar**

Within one business day of notification of enrollment, the Mercy Care Plan (MCP) Long Term Care (LTC) Intake Coordinator reviews the members Pre-Admission Screening (PAS) and determines that Oscar's case will be assigned to the Case Manager (CM) dedicated to the Nursing Facility (NF) and enters this assignment into CaseTrakker™. This entry auto-generates an immediate alert to the CM that they have a new assigned member and the due date of the initial assessment. The Intake Coordinator links the member's PAS to the CaseTrakker™ record for the CM's review. This process provides the CM with an electronic copy of the PAS so it is easily assessable to the CM and other MCP personnel.

The CM reviews the PAS to learn about Oscar's medical issues, functional needs, and other background information (including Prior Period Coverage (PPC) eligibility). The CM identifies Oscar is married and his wife April is listed as a representative. Within five business days of enrollment, the CM contacts the NF, Oscar, and April to notify them of Oscar's MCP LTC enrollment. The CM invites April to be present at Oscar's assessment and schedules the assessment at a time that is convenient for her, but no later than 12 business days after the enrollment date. Prior to the assessment with Oscar and his wife, the CM reviews Oscar's NF chart including current doctor's orders, nursing notes, therapy notes, all records sent from the rehabilitation center and the hospital, and obtains copies of his current pharmacy orders.

For Oscar's and April's privacy (HIPAA), the CM meets with them in his NF room. As part of this interview, the CM explains to Oscar and April the role of the CM in: 1) needs assessment, service planning, and coordination, 2) brokering of services to maximize the effectiveness of the service plan, 3) facilitating and advocating on the member's behalf for covered and non-covered community-based services, 4) ongoing monitoring and reassessment of the member's needs, 5) gatekeeping through assessment of needs, including determination of ALTCS services cost effectiveness, and 6) identifying and coordinating benefits, Medicare and Third Party Liability (TPL). During the interview, the CM conducts an assessment of Oscar's medical condition(s), functional, and psycho-social needs. In performing this member-centered assessment and care planning the CM applies their training, experience, and knowledge to identify and respond to Oscar's and April's preferences, interests, needs, language, culture, and belief systems.

During the initial assessment, the CM gives and reviews with Oscar and April a new member packet. This packet includes a: a) member handbook, b) provider directory including a zip code specific urgent care listing, c) information on HIPAA, d) member rights and responsibilities acknowledgement, e) Critical Service Gap Report Form, f) self-directed attendant care pamphlet, and g) advance directives form. The CM also thoroughly reviews items from the Member Handbook such as: the entire spectrum of LTC services, behavioral health crisis line, no-cost translation and transportation services, and instructions on how to file a grievance or appeal. Oscar and April are asked to sign a member packet acknowledgement form indicating they have received all the information described above, that items have been reviewed and that they understand what has been received. The CM advises Oscar of the name and contact information of his assigned PCP and how to request a change of his PCP assignment. Oscar is also made aware of our Patient Centered Medical Home (PCMH) program that serves members through "in-home" visits at the member's placement (NF, ALF or the member's home) that is part of his PCP choice options.

Prior to completing the assessment tools, the CM gathers information about Third Party Liability (TPL) coverage, such as worker's compensation, employer, or Veteran's benefits, to make certain maximum benefits are accessed and payer structure is followed. If there is evidence of TPL, the CM will investigate which portions of Oscar's health care needs are covered by the TPL; explains this process to the family and offers to provide on-going assistance in coordinating benefits.

The CM explains to Oscar and April about eligibility for PPC and if applicable, that MCP is responsible for Oscar's medical expenses prior to enrollment with MCP. The CM also explains Share of Cost (SOC) to Oscar and April and recommends they complete an application for Social Security Disability Income (SSDI). Additionally, the CM recommends that April apply for TANF benefits.

The CM completes MCP's Assessment Tool, Skin and Fall Evaluation (SAFE) tool, and AHCCCS' Uniform Assessment Tool (UAT) to identify Oscar's current medical, functional, psycho-social strengths and needs, his level of care, culture and beliefs, and formal and informal supports. The CM also asks Oscar and April about their immediate and long-term goals while he is in the facility and his desire to return to his home and family and eventually back to work. Oscar and April are asked to outline the issues that each perceives need to be resolved before Oscar can go home. The CM also asks Oscar about his satisfaction with the services provided in the NF, identifies issues to be investigated and, if necessary, files a grievance on Oscar's behalf.

The CM informs Oscar and April that the NF holds care plan meetings. The CM meets with the NF Social Worker (SW) to discuss Oscar's case, issues that Oscar and April identified, and requests that a discussion of Oscar's care plan be added to the next weekly NF multi-disciplinary team meeting.

Based on the CM's assessment, in collaboration with Oscar, April, and the care team, the following issues are identified; the first five are priority and will be addressed concurrently. The CM will initiate action on these priority issues within one (1) to two (2) business days of completing the assessment. Issues 6-10 will be addressed concurrently after there is a plan to resolve Oscar's immediate issues (within seven business days of completing the assessment). In collaboration with Oscar, April, and the NF multi-disciplinary team, the CM develops a member-centered care plan.

**1. Issue:** Oscar is sleeping in late, recently experiencing forgetfulness (as evidenced by his inability to recall PT he just received) and confusion, and NF staff says he appears depressed and gets agitated when they come to provide care. **Plan:** The CM discusses service options with Oscar and April, and recommends they consider individual counseling and psychiatric services for Oscar and family counseling for April and other family members. Based on Oscar and April's desires, the CM consults with the MCP BH Coordinator regarding the need for a referral for a psychiatric evaluation and counseling services. The psychiatrist will assess Oscar in conjunction with the PCP to determine if his confusion and disorientation are a result of a medical condition or due to an evolving BH condition. The CM requests the NF PCP to review Oscar's medications to determine if any could be causing sedation/confusion. The CM also discusses a peer support referral to help Oscar adjust and prepare for future transition back home. **Desired Outcomes: Short-term-** Oscar will have an evaluation of his medical and behavioral health needs to evaluate his sleeping in late, recent occurrences of forgetfulness, confusion, appearing depressed and instances of displaying agitation. **Long-term-** Oscar and April report an improvement in managing his sleeping in late, forgetfulness, confusion, appearing depressed, and instances of displaying anger.

**2. Issue:** Oscar complains that his custom wheelchair is hard to maneuver. **Plan:** As part of the care plan that Oscar agreed to the CM asks the NF staff to have the wheelchair provider come to the NF to do a new seating evaluation. The CM requests the PCP order a Physical Therapy (PT) and Occupational Therapy (OT) evaluation to determine if there possibly are other issues that need to be addressed for Oscar to better maneuver his wheelchair. The CM follows-up timely (no later than 7 calendar days) with NF staff and April to determine if the wheelchair evaluation and PT/OT has been ordered and completed. **Desired Outcomes: Short Term-** Oscar will have his wheelchair evaluated and a PT/OT evaluation completed. **Long-term-** Oscar will be able to operate his wheelchair independently.

**3. Issue:** Oscar complains he is not getting enough Physical Therapy (PT). **Plan:** The CM discusses with Oscar and April the amount of PT he was receiving in the rehabilitation facility and what he is receiving now in the NF. The CM recommends to Oscar and April that they put a calendar in Oscar's room to record the dates and times of Oscar's PT appointments. Following this discussion, the CM will meet with the NF staff, including the physical therapist, to review Oscar's complaint and assess whether his PT needs are being adequately met. The CM asks the PCP/physical therapist to clearly explain the amount of PT authorized as medically necessary to Oscar and April and to describe the process to obtain additional PT units if needed. **Desired Outcomes: Short-term-** Oscar will have a clear understanding of the amount of physical therapy necessary for him to reach his highest level of functioning; **Long-term-** Oscar receives the medically necessary physical therapy to reach his highest level of functioning.

**4. Issue:** Oscar says the NF caregivers handle him "roughly" and are not as responsive as at "the last place". **Plan:** Oscar and April discuss dissatisfaction with the care he is receiving at the NF with the CM. The CM encourages Oscar and April to bring up issues to the NF staff and to the CM. In addition, if Oscar requests, the CM will arrange for a care plan staffing meeting with the NF staff, Oscar, and April to address Oscar's complaints. The CM reviews the NF chart and discusses Oscar's complaints with the NF SW and Director of Nursing (DON). As part of this discussion, the CM will explore if any elements of Oscar's care and handling can be improved. The CM completes and submits a member grievance on Oscar's behalf. The grievance is reviewed by MCP's grievance workgroup for investigation and referral to the appropriate MCP department (e.g., Provider Services for provider performance or Quality Management for quality of care concerns) for follow-up, if needed. The CM follows-up with Oscar and April to see if they are now satisfied with Oscar's care and treatment. **Desired Outcomes: Short-term-** Oscar's immediate issues are addressed and communication continues with the NF staff. **Long-term-** Oscar will be satisfied with his care and treatment.

**5. Issue:** Oscar states there is nothing for him to do at the NF and the other NF residents are "too old". **Plan:** Based on discussion with Oscar and April the CM facilitates a meeting with the NF Activities Director to determine Oscar's interests and develop an activity plan. The activity plan should include approaches for involving Oscar in meaningful social activities at the NF. Additionally, the CM recommends, with Oscar's agreement, that the Activities Director

schedule a family night where Oscar's family/friends can visit, have dinner, and socialize. The CM requests the PCP consider an OT referral to suggest therapeutic activities that would benefit Oscar's rehabilitation. **Desired Outcome:** **Short-term-** Oscar will have meaningful activities and social interactions while at the NF. **Long-term-** Oscar will be able to self-identify activities to participate in.

**6. Issue:** Oscar feeds himself, but since he is wearing a splint, eating is messy. **Plan:** The CM discusses with the NF staff about following Oscar's rehab plan and requests an OT evaluation order from the PCP to determine if any additional adaptive aids or food options may improve his independence. The CM asks the PCP/OT to clearly explain the amount of OT authorized as medically necessary to Oscar and April and to describe the process to obtain additional OT units if needed. The CM requests that the NF staff include April in some OT sessions so she can support his independence upon his discharge home. **Desired Outcomes:** **Short-term-** Oscar will have an OT evaluation to determine his needs. **Long-term-** Oscar will have the necessary adaptive aids to work to his highest potential in feeding himself.

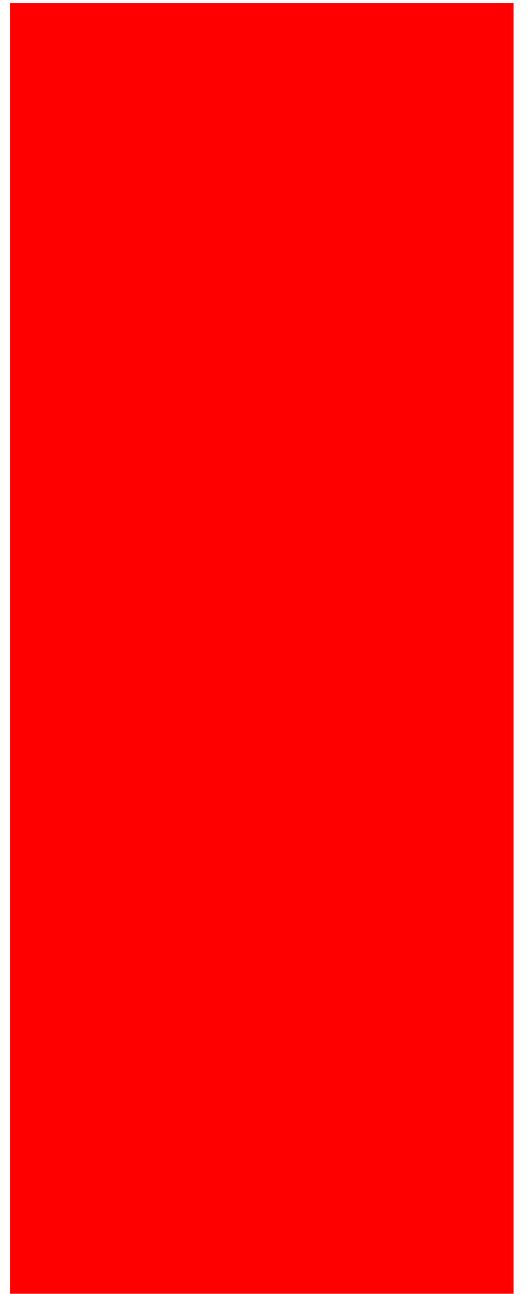
**7. Issue:** April doesn't think she can provide all of the care Oscar requires, including bowel care. April is concerned a full-time income is needed to support their family and she will be unable to meet Oscar's care needs. **Plan:** Because Oscar is interested in going home, the CM goes over the service options for personal and bowel care available to Oscar and April, so they can make an informed choice as to their options to meet Oscar's needs. These options include Skilled Self-Directed Attendant Care (SDAC), Spouse Attendant Care (SAC), Agency Attendant Care (Agency), Home Health Nursing, and Respite Care. The CM informs the family that services in the home need to be cost effective and explains what that means. The CM explains the 40 hour per week limit under SAC. The CM explains both the Agency and Skilled SDAC models if Oscar and April choose to have Oscar's brother as a caregiver and he agrees. The CM advises Oscar and April that Skilled SDAC service would allow for more Attendant Care hours to be authorized, if Oscar's brother is willing to provide bowel care and is trained and approved by a RN. If Oscar and April choose the Agency model, then the CM would authorize home health services to address his bowel care needs. The CM recommends April receive bowel and personal care training while Oscar is in the NF so that she understands his bowel and personal care needs. The CM will coordinate and authorize the type of Attendant Care and home health services based on Oscar and April's choice. The CM will update the care plan and coordinate the services that Oscar and April have chosen so that the services are available upon Oscar's discharge. The CM will authorize Respite Care if Oscar and April choose to have the service available after discharge home. **Desired outcomes:** **Short-term-** Based on Oscar's and April's choices, a plan will be established to meet Oscar's Attendant Care and bowel care needs. **Long-term-** Oscar will discharge home with medically necessary services in place,

**8. Issue:** There are accessibility issues at Oscar's home, primarily at the entrance and in the master bathroom. **Plan:** The CM asks the NF PT to identify Oscar's basic DME needs once he moves home. The CM explains to Oscar and April the DME options that may be available including, but not limited to, a hospital bed, hooyer lift, and wheelchair ramp. Any medically necessary DME must be ordered by the PCP and in place at the time of Oscar's discharge. The CM informs Oscar and April that medically necessary home modification is an option. Their choices may include having the doorways widened at both the entrance and master bathroom and installation of a roll-in shower to help Oscar maintain his independence. The CM authorizes and schedules a home modification evaluation to be completed, while Oscar is home for a visit, prior to his discharge. **Desired outcomes:** **Short-term-** Oscar will have the medically necessary DME and home modification evaluation needed for discharge home. **Long-term-** Oscar's home is configured so that he can be as independent as possible.

**9. Issue:** Oscar talks a lot about working again to help support his family. **Plan:** In order to give Oscar the opportunity to explore his potential to go back to work, the CM provides Oscar and April with employment and education resources available to him. If Oscar chooses, the CM will make a referral for Vocational Rehabilitation after he is discharged home. **Desired outcomes:** **Short-term-** Oscar will receive all information necessary to make a choice regarding his education and future employment opportunities. **Long-term-** Oscar will develop skills for future employment and eventual return to the workforce in order to contribute to the support of his family.

**10. Issue:** April asked about assistance to obtain a wheelchair van. **Plan:** The CM explains to Oscar and April that this is not an AHCCCS covered service. However, CM informs April that the AHCCCS transportation benefit includes wheel chair van rides to any medical appointment or to pick up medications at the pharmacy. The CM provides April a list of community resources that could help provide a wheelchair accessible van. **Desired Outcomes:** **Short term:** Oscar and April understand the AHCCCS transportation benefit. **Long term:** Oscar and April will understand the community resources available to assist with acquiring a wheelchair van.

24-B



## Question 24 – Case Management

### B. Magda

Within two (2) business days of the change in Case Managers (CMs) the sending CM, following MCP's standard operating procedure will: 1) create a chart transfer progress note in CaseTrakker™ explaining the reason for the transfer of the member's case to the new CM and the member's current status; 2) discuss this information with the new CM; 3) reassign the member's case file and related tasks (e.g., need for follow-up on obtaining diabetic screenings) electronically in CaseTrakker™ to the new CM, immediately triggering a CM change letter to the member; 4) creates a chart transfer checklist to confirm all steps were completed; 5) provides an electronic and hard copy of the member's file to the LTC supervisor for review prior to transfer to the new CM. Within one (1) business day of receiving the chart, the LTC supervisor will note any oversights or omissions to the file for correction prior to transferring the case to the new CM. Within one business day of the change in CMs the previous CM contacts the member to advise of transition to new CM. When a case is reassigned to a new CM in CaseTrakker™, the system electronically moves the member's case from the original CM to the new CM, as well as adding the reassessment due date. MCP's standard operating procedure requires that when a member's case is reassigned, the new CM must contact the member by phone within 2 business days to introduce themselves to the member and member's family/caregiver<sup>3</sup>. If the reassessment is due or per the member's request, the new CM schedules the reassessment with the member at their home-based on the member's convenience but no later than the assessment due date.

The new CM makes a visit to complete a reassessment of Magda's needs. The CM provides Magda and her daughter with all appropriate contact information for the new CM. During the reassessment visit the CM uses our translation service Language Line® Interpreter Services to ask Magda if she wants Raquel involved in the assessment process and future decision making and how she wants translation handled. If Magda chooses to have Raquel involved, the CM will respect that choice, and make a note in CaseTrakker™. The CM explains to Raquel it is important that Magda be included in assessment, planning, and discussions about her care. This respects Magda's dignity, individuality, and right to choose.

The CM initiates actions on the identified issues during the assessment and completes CM actions within seven (7) business days of completing the assessment. The following issues have been identified and are addressed concurrently:

**1. Issue:** Raquel is requesting more hours of attendant care because of Magda's increased confusion, recent falls, and diagnosis of early stages of dementia. The CM assessed that Magda needed less hours of service than the prior assessment. **Plan:** The CM incorporates information provided by Magda and Raquel in completing the assessment tool, attendant care worksheet, and the acuity tool to identify the amount of assistance that Magda needs for her personal care, housekeeping, and supervision. The CM uses the attendant care worksheet as a guide in determination of attendant care hours required to safely meet Magda's needs. The CM reviews the worksheet with Magda and Raquel and discusses the differences between what was requested and what the CM had originally determined. After considering the additional information that Raquel presented about Magda's need for supervision, due to dementia and being unsafe to be left alone, the CM increases the service hours to provide supervision for Magda until a family member returns home. The CM completes a new care plan and presents it to Magda and Raquel, for their approval and signature. **Desired Outcome:** **Short-term:** Magda's changing needs are addressed and additional hours of attendant care are authorized. **Long-term:** Magda remains in the least restrictive environment by continuing to live in her daughter's home.

**2. Issue:** Magda is at risk for falling as evidenced by continued unsteadiness without guidance, falling a few times while walking with her walker, and recently falling in the shower. **Plan:** As part of the routine assessment and Magda's recent falls, the CM completes the Skin and Fall Evaluation (SAFE) tool, which includes a fall risk assessment and provides and reviews with Magda and Raquel a brochure from the Center of Disease Control (CDC) that identifies home environmental obstacles considered fall risks. The CM informs Magda's PCP that she is at risk for falls and requests a complete medical evaluation to determine if there are medical reasons for falling. Because Magda has fallen in the shower, the CM requests that the PCP write an order for grab bars, a shower chair, and any potential DME the PCP recommends. **Desired Outcome:** **Short-term-** Magda is to be evaluated by PCP and receive any medically necessary DME to prevent falls. **Long-term-** Minimize Magda's fall risk to safely remain in her daughter's home.

**3 Issue:** There have been times recently when the caregiver didn't show up on time and Raquel had to stay home from work until someone else was available to take over for her. **Plan:** The CM contacts the attendant care agency to make sure they are aware that the caregiver has been late arriving to Magda's home and that as a result, Raquel had to stay home

---

<sup>3</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

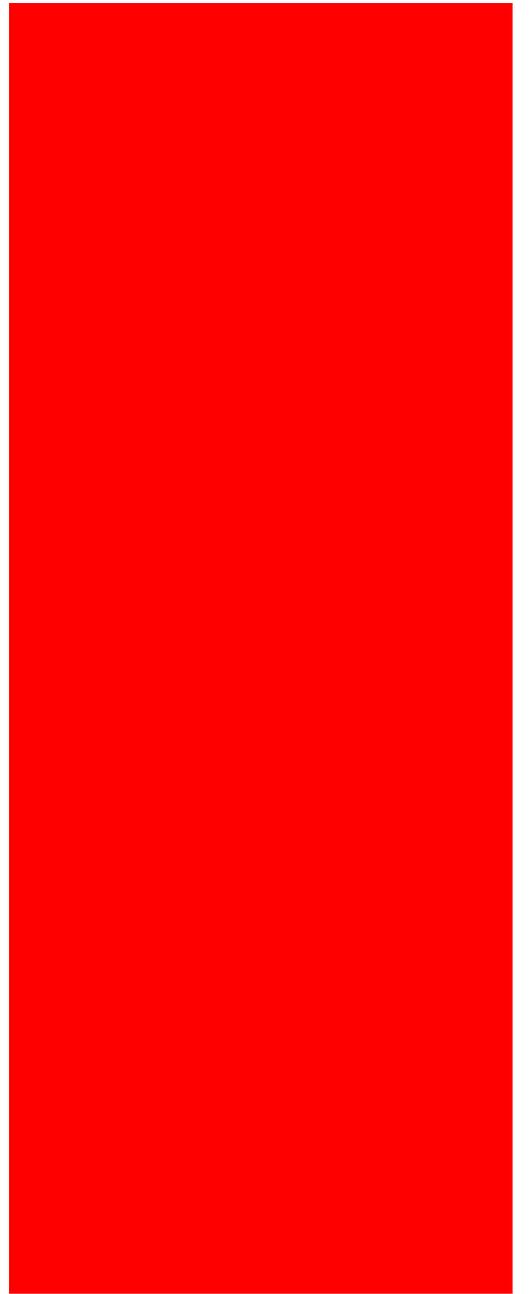
from work until the caregiver arrived. The CM contacts the agency within one (1) business day of completing the assessment and requires the agency to: 1) educate/re-educate the attendant caregiver to notify both the agency and Magda in advance if the caregiver is going to be late, in the future; 2) in the event the caregiver is ever late again, the agency must contact Magda to determine a) her preference of a replacement caregiver and b) how soon she wants the caregiver service; 3) report future incidents on the Non-Provision of Service log. The CM will continually monitor the availability of attendant care for Magda and if there are future service disruptions, with Magda's agreement, the CM may ask the agency to use another caregiver or the CM may choose another agency. The CM will file a member grievance on behalf of Magda's reporting the problem of the caregiver being late. The CM reviews the Contingency Plan with Magda and Raquel and they choose a Member Service Preference Level to meet Magda's needs. As a result of the CM's review with Magda and Raquel of the Contingency Plan, Magda and Raquel know the phone numbers (e.g. caregiver agency, the MCP CM, and AHCCCS) in case the caregiver does not show up as scheduled. Magda and Raquel may identify an optional caregiver replacement in the Contingency Plan. The CM informs Magda and Raquel of their right to choose how and when to replace the regular caregiver, and that informal supports are not required to be replacement caregivers. **Desired Outcomes:** *Short-term-* The agency will send an alternate caregiver within the time chosen by Magda and Raquel, if the regular caregiver is unavailable. *Long-term-* Magda will continue to receive her attendant care as scheduled.

**4. Issue:** Raquel has asked for a new PCP for her mother because she is having difficulty making appointments with the current PCP. **Plan:** The CM will ask Magda and Raquel to describe the issue so that the CM can determine the cause of the dissatisfaction. Due to the difficulty scheduling appointments, the CM submits a Grievance Form on Magda's behalf. The CM discusses options for a PCP change with Magda and Raquel, which may include: 1) resolving issues with current PCP office; 2) changing to a new PCP, preferably Romanian-speaking if available; 3) a patient-centered medical home, which has extended office hours; 4) Patient Centered Medical Home (PCMH) program that serves members through "in-home" visits at the member's placement (NF, ALF or the member's home). The CM assists Magda in changing to a new PCP, if that is her choice. If she chooses to change PCPs, the CM will call the current PCP office and will request for medical records to be transferred to the new PCP and notify the new PCP of any specialists involved in her care. To facilitate communication with her PCP, the CM completes MCP's PCP Initiative Form with Magda. MCP's PCP Initiative Form helps Magda communicate her symptoms and questions about her medical conditions with her PCP, including the need for diabetic testing and that she is on dialysis. **Desired Outcomes:** *Short-term- 1)* Magda will understand her options for PCP care. *Long-term-* Magda will have routine, consistent access to a PCP of her choice when she needs care.

**5. Issue:** Magda is in the early stages of dementia and Raquel feels that her confusion has increased. **Plan:** The CM discusses with Magda and Raquel the challenges associated with caring for and having the early stages of dementia. The CM offers community resources such as the Alzheimer's Association which provides resources and education for members and families living with dementia. Raquel and the family will be encouraged to attend regularly scheduled support groups offered for caregivers and to perhaps take Magda, since individuals in the early stage of the disease are also invited to the meetings. The CM asks for a copy of Magda's signed Advanced Directives in order to document Magda's choice for her future care. The CM will send a copy of the Advanced Directives to Magda's PCP. The CM advises Magda and Raquel to discuss Magda's increased confusion with her PCP. **Desired Outcome:** *Short-term-* Magda and her family will understand and have resources to address her dementia. *Long-term-* Magda's will remain at home as long as possible with support services in the most integrated setting.

**6. Issue:** Magda misses getting out and going to church. Raquel is requesting respite services on Sundays so that she can leave Magda at home while attending church. **Plan:** The CM will ask Raquel to explore the option of having someone from the church come to the home for pastoral services. For socialization, the CM informs Magda and Raquel about one of MCP's Adult Day Health Care centers, which is multi-cultural and multi-lingual (including Romanian). This center also has a transportation service with drivers who speak Romanian, and can provide transportation to medical appointments and to dialysis. The CM will also inform Magda and Raquel that MCP has a number of Romanian speaking adult foster care homes that could be used for extended respite care. The CM offers respite care service on Sundays so that Raquel and her family can go to church. **Desired Outcomes:** *Short-term- 1)* Magda and Raquel will understand their options for culturally appropriate socialization. *Long-term-* Magda will have an opportunity to get out and socialize with others who are from her culture and speak her primary language. 2) Raquel and her family are comforted that Magda is safe while they attend church as a family.

24-C



## Question 24 – Case Management

### C. Wanda

Wanda's Case Manager (CM) contacts her and schedules an appointment for an assessment at the Assisted Living Facility (ALF) to take place as soon as possible but no later than 10 working days from the date she was readmitted to the ALF, due to significant changes in the member's condition and change in placement. The CM asks Wanda whether she'd like to have her son and/or any other family members involved during the assessment. In the event that Wanda indicates she would like her son or other family members involved, her CM will invite him to participate in the assessment.

Prior to meeting with Wanda for the assessment, the CM reviews the ALF records and facility care plan. The CM also reviews the ALF chart for the recent hospitalization records and talks to the staff to determine what kind of assistance they are providing Wanda and if there are any issues that may require further consideration. In order to provide privacy, the CM conducts the assessment in Wanda's room at the ALF.

Mercy Care Plan's (MCP's) Assessment Tool was developed with the goal of assisting the member and the member's family/caregiver<sup>4</sup> and the CM to recognize: 1) the member's strengths and needs; 2) cultural considerations; 3) the member's capacity to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL); 4) the potential need for behavioral health services; 5) formal and informal support system; 6) the need for Durable Medical Equipment (DME); 7) current living situation; 8) if the member has and is attending scheduled appointments with their PCP/specialist; 9) history of recent hospitalizations or ED use; 10) current medication and medical conditions; 11) members' self reported level of pain; 12) the member's need for a specialty diet and their adherence to it; 13) any reported incidents of neglect, abuse or exploitation; and 14) preferred contact information. The CM will complete an assessment for Wanda, utilizing this tool. The outcome of this member-centered assessment will provide the information required to develop Wanda's care plan.

It is MCP's standard operating procedure to complete the Skin and Fall Evaluation (SAFE) for each member at all assessments. Our SAFE tool is divided into two sections. The first section addresses members at risk for skin breakdown based on factors such as incontinence and immobility. Members identified as being at risk for skin breakdown are offered an RN visit as part of their care plan. If the RN identifies a need for treatment, the CM will coordinate care with the member's primary care provider (PCP) and request/authorize services. The second section of the SAFE tool addresses a member's risk of falling.

Should, as a result of the assessment, the CM determine the member is at risk of falling, the CM uses the Center for Disease Control (CDC) fall prevention brochure/checklist. The checklist allows the CM to identify hazards in the member's residence that could cause a fall. The CM reviews the brochure with the member and the member's family/caregiver, and the facility at the time of the assessment. The brochure describes how to provide a safe environment and prevent falling. The CM will identify if the member is on any medications that could increase the risk of falling and notify the PCP within two (2) business days of completing the assessment.

During the assessment the CM, in corroboration with Wanda and her son, identifies Wanda's current medical, functional, and psychosocial needs, formal and informal supports, and determines, her short and long-term goals. Based on this assessment the following issues were identified.

These issues are addressed concurrently by the CM during the assessment. The CM will initiate action at the time of the assessment and complete all CM actions within seven (7) business days of the assessment.

**1. Issue:** Since returning from her last hospitalization Wanda is non-ambulatory and needs near total care for her ADLs including feeding. **Plan:** The CM uses the information gathered from the hospital discharge plan, the ALF care plan, and the completed member-centered assessment, developed in collaboration with Wanda and her son to develop her care plan. As part of the overall assessment the CM completes MCP's SAFE tool to determine her fall and skin breakdown risk. The CM discusses with Wanda and her son the potential risks associated with skin breakdown. If the SAFE tool indicates that Wanda is at risk for skin breakdown, the CM notifies Wanda's current PCP within one (1) business day of completing the assessment and requests that the PCP order a home health nurse to assess Wanda's skin integrity. The home health nurse will be asked to notify the PCP of the assessment results and the need for any Durable Medical Equipment (DME) such as a specialty mattress that could help prevent pressure ulcers and to provide training to the facility staff to know how to properly care for Wanda's special needs. A care plan meeting will be requested by the CM within one week,

---

<sup>4</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

including Wanda, her son, the PCP, and the facility staff to address the importance of Wanda's near total care needs, including feeding, and determine whether or not Wanda's needs can be adequately met in the current setting. During the care plan meeting, the CM will inform Wanda and her son of all service options available including: 1) remaining in her current placement; 2) moving to an ALF with a higher level of care; 3) Wanda being able to return to her son's home setting with additional cost effective in-home services; and 4) a Skilled Nursing Facility placement if none of the other options are able to meet her care needs. **Desired Outcomes:** *Short-term-* A comprehensive, individualized care plan will be developed to address Wanda's current needs. *Long-term-* Wanda's needs will be met in the safest and most integrated setting.

**2. Issue:** Wanda is diagnosed with diabetes, peripheral neuropathy, hypertension, and congestive heart failure and she is enrolled in a Medicare Advantage Plan that is not associated with MCP. **Plan:** Prior to the assessment the CM reviews the facility records to determine whether medication and care orders have been received from the PCP. The CM also reviews the record to see that the ALF is overseeing the medication administration and that the medication administration record (MAR) is being completed. The CM, ALF, and PCP will collaborate so that Wanda receives a yearly flu shot, diabetic testing, and keeps scheduled medical appointments for her PCP and specialists. The CM discusses with Wanda and her son how coordination of care is improved when the member is enrolled in MCP's MAP and uses a contracted PCP, especially since Wanda has multiple comorbidities and her condition has declined. The CM explains that MCP LTC members enrolled with Mercy Care Advantage are able to use the contracted Patient Centered Medical Home (PCMH) program that serves members through "in-home" visits at the member's placement (NF, ALF or the member's home). The CM will assist in coordinating care with Wanda's current PCP and MAP if Wanda would like to continue with her current plan. If Wanda and her son choose to enroll in the PCMH program described above, and choose to enroll in MCP's MAP, the CM will assist in coordinating the change so Wanda will be eligible at the beginning of the following month. **Desired Outcomes:** *Short-term-* Wanda will see her PCP on a regular basis. Wanda and her son will have enough information to make an informed decision regarding enrollment in MCP's MAP or remain with their current MAP. *Long-term-* Wanda's chronic medical conditions will be managed and continuity of care will be maintained.

**3. Issue:** Wanda is more confused and sometimes combative. **Plan:** The CM will talk with Wanda, her son, and facility staff to gather details regarding Wanda's increased confusion and combativeness. The CM then contacts Wanda's PCP within one (1) business day of completing the assessment and notifies him/her of Wanda's increased confusion and combativeness and asks the PCP to evaluate if necessary. The CM will ask the PCP to determine if a Behavioral Health (BH) referral is needed. If the PCP determines that a BH referral is needed, the CM will consult at the same time with the MCP BH Coordinator and the Psychiatric Medical Director. If BH services are recommended, the CM will discuss the services available with Wanda and her son, and if she agrees a referral will be made. The CM works with the BH Coordinator to make a BH referral if warranted. **Desired Outcomes:** *Short-term-* Wanda will receive evaluation of her medical and behavioral health needs. *Long-term-* Wanda's confusion and combativeness will be effectively managed.

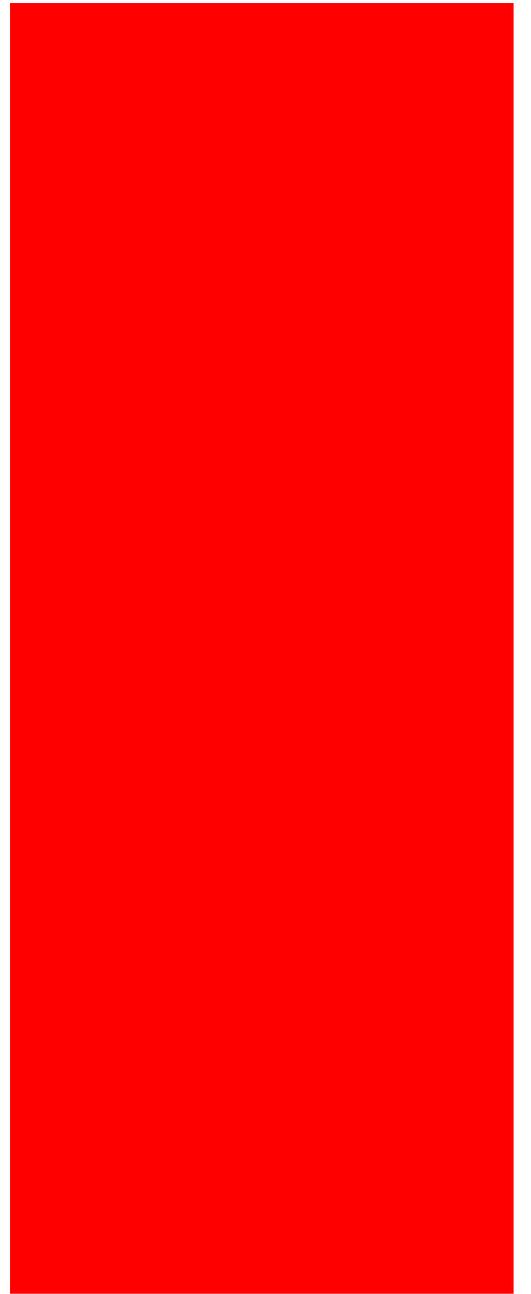
**4. Issue:** Wanda had several falls at home before placement in the ALF and continues to fall at the ALF, although now she is non-ambulatory. **Plan:** The CM completes the Skin and Fall Evaluation (SAFE) tool to determine her risk for falling. The CM talks to the ALF staff about the need to have a care plan that addresses fall risk, and that may include items such as a bed or chair alarm to decrease the risk of falls. Within one (1) business day of the assessment the PCP will be asked to review Wanda's medical status and her medications to see if they could have contributed to her falls. The CM will communicate with Wanda, her son, and the ALF staff to determine what actions were taken after the first fall. They will also be asked 1) what the circumstances of the falls were 2) to identify other known factors that caused the fall, 3) if the falls were documented and reported to the PCP. Within two (2) business days of the assessment the CM will complete and send a Quality of Care Concern report regarding the falls that have occurred at the facility to the MCP QM Department. The report will initiate an investigation that could lead to the ALF being issued a corrective action plan. **Desired Outcomes:** *Short-term-* The ALF will report falls to the CM and PCP and have a care plan in place which includes fall prevention measures. *Long-term:* Wanda will have no further falls.

**5. Issue:** Wanda has been recently diagnosed with pelvic cancer and has started treatment. **Plan:** The CM contacts the PCP within one (1) business day of the assessment to inform the PCP of Wanda's recent hospitalization and newly diagnosed pelvic cancer, in the event that he/she is not already aware so that the PCP can coordinate her medical care. Depending on Wanda's care plan, the PCP may want to consider if hospice is an appropriate option for Wanda. If hospice is appropriate, the PCP will discuss the option with Wanda and her son to determine what their wishes are. The CM will arrange for any needed increase in the frequency of home health nursing or additional DME ordered by the PCP. Within one business day of the assessment the CM will staff the case with the MCP BH coordinator and then offer individual and family counseling to help Wanda and her son deal with her new cancer diagnosis. **Desired Outcomes:** *Short-term-*

Wanda and her son will understand her options to meet her medical and emotional needs. **Long-term-** Wanda and her son will be able to make informed decisions regarding her ongoing medical care and will receive the necessary support to remain in the least restrictive setting.

**6. Issue:** Wanda's son moved her into an ALF without the CM's knowledge. **Plan:** The CM asks Wanda and her son about the circumstances that necessitated the change in placement. The CM will discuss their role, emphasizing the importance of contacting the CM whenever there is a change in Wanda's care needs or condition, and that notification of status changes will allow the CM to implement appropriate services in a timely manner. The CM will complete a room and board agreement at the time of the assessment, which covers her from the date placement, and review with Wanda and her son and asks them to sign the agreement. If Wanda is in an Assisted Living Center, the CM will discuss Wanda's Single Occupancy rights and reviews and completes the Single Occupancy form with Wanda. The CM will create an authorization for the ALF within seven (7) business days of the assessment. **Desired Outcomes:** **Short-term-**Wanda and her son will understand the benefits of keeping the CM involved in her care. **Long-term-**Wanda will be able to remain in the facility of her choice as long as her needs can be met.

24-D



## Question 24 – Case Management

### D. Roger

Within one (1) business day of notification of enrollment, the Mercy Care Plan (MCP) Long Term Care (LTC) Intake Coordinator will review the functional and behavioral needs of Roger and refer the intake to the Behavioral Health (BH) Supervisor for review and assignment of a BH Case Manager (CM). The BH Case Management team consists of specialized Long Term Care CMs who at a minimum have a master's degree in a behavioral health field and experience in BH case management.

Within five days of enrollment per MCP's standard operating procedure, the BH CM contacts Joyce (Roger's sister/guardian) to schedule a home visit. The home visit is scheduled to occur within twelve (12) business days of enrollment. During this initial phone call, the BH CM asks Joyce if she would be available for the visit to occur the following day based on issues Joyce had identified. The BH CM asks Joyce when the next PCP appointment is scheduled and offers to assist in scheduling an expedited appointment with the PCP. If the PCP needs to be changed, the BH CM will work with Member Services staff to change the PCP. The BH CM requests that Joyce have available at the time of the assessment any of Roger's records from out-of-state, along with guardianship paperwork. If she does not have Roger's prior medical records, the BH CM will recommend that Joyce executes a Release of Confidential Information form necessary to request medical and psychiatric records from Roger's previous providers. The BH CM inquires if Roger has been receiving behavioral services since moving to the state. If he is currently receiving services from a provider contracted with RBHA, the BH CM will work with the BH Coordinator to facilitate transition of care within 30 days. Before ending the initial phone call, the BH CM will provide Joyce with the MCP BH crisis phone number and the location and phone number of the closest Urgent Care facility.

The day following the CM phone call to Roger and Joyce, the BH CM arrives at the home for the assessment, introduces himself/herself to Roger and Joyce, and presents the new member packet including the member handbook. The BH CM reviews the handbook and focuses on the services available from MCP LTC and contact information for the CM. CM begins establishing a trusting relationship by engaging Roger and Joyce in a conversation about their current situation. The CM explains services specific to Roger's medical and BH needs. The CM completes the assessment, SAFE tool, Uniform Assessment Tool (UAT), attendant care worksheet (based on identified need) to identify all biopsychosocial and cultural needs. The BH CM asks Roger/Joyce what the goals are. Joyce states she would like Roger's seizures to be better managed. In addition she requests that Roger: 1) be involved in the community so he is not in his room all day and bored, 2) stop smoking cigarettes, and 3) control his behaviors. The care plan will also be completed and reviewed with Roger and Joyce. During the assessment the BH CM will obtain Joyce's signature on the care plan. The BH CM will also obtain a copy of the guardianship papers at the initial assessment and file them in the case management record. A copy will also be sent to the MCP Compliance Officer. The BH CM will educate Joyce about the value of Roger having regularly scheduled appointments with his PCP. The BH CM recommends that Roger receives the Influenza vaccination annually because he is at high risk for flu. The BH CM also recommends that Roger discuss smoking cessation with his PCP.

Within seven (7) business days of the assessment the BH CM will discuss the case with the BH case management team. MCP's BH team includes: BH Medical Director, the BH coordinator, and the BH team supervisor.

These issues are addressed concurrently by the BH CM at the time of the assessment. All BH CM actions are initiated and completed within seven (7) business days of the assessment.

**1. Issue:** Roger is displaying resistance to care, verbal and physical aggression, fabrication and elopement attempts.

**Plan:** Within one (1) business day of the assessment the BH CM will make a referral to: 1) an outpatient psychiatrist for medication management and 2) for neuropsychological testing, and 3) to the Consultation and Clinical Intervention (CCI) program. The CCI team: a) will complete a functional analysis, b) develop a BH management and crisis plan, c) provide direct care and individual counseling to address grief and Roger's recent transition to Arizona, d) work with Roger/Joyce to successfully implement the BH management plan. Joyce will have access to the MCP Behavioral Health Crisis phone number that is available 24 hours-a-day, 7 days-a-week and CCI team's after-hours line. Joyce will be provided with family/caregiver<sup>5</sup> support group information, such as the Brain Injury Association of Arizona, Alliance for the Mentally Ill and TBI Caregivers Support Group. Calls to the MCP BH Crisis Line may result in de-escalation during the call or a mobile crisis team being sent to the home to help with de-escalation and assessment of need. Since an elopement risk is

---

<sup>5</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

identified, the BH CM and the CCI team will jointly discuss options to reduce the risk of elopement. These options may include, but are not limited to, attendant care, Traumatic Brain Injury (TBI) Adult Day Health Program, and referral to community resources to assist in securing the residence. **Desired Outcome:** *Short-term* – Roger’s behaviors will be managed. *Long term* – Roger will be able to safely remain in his sister’s home.

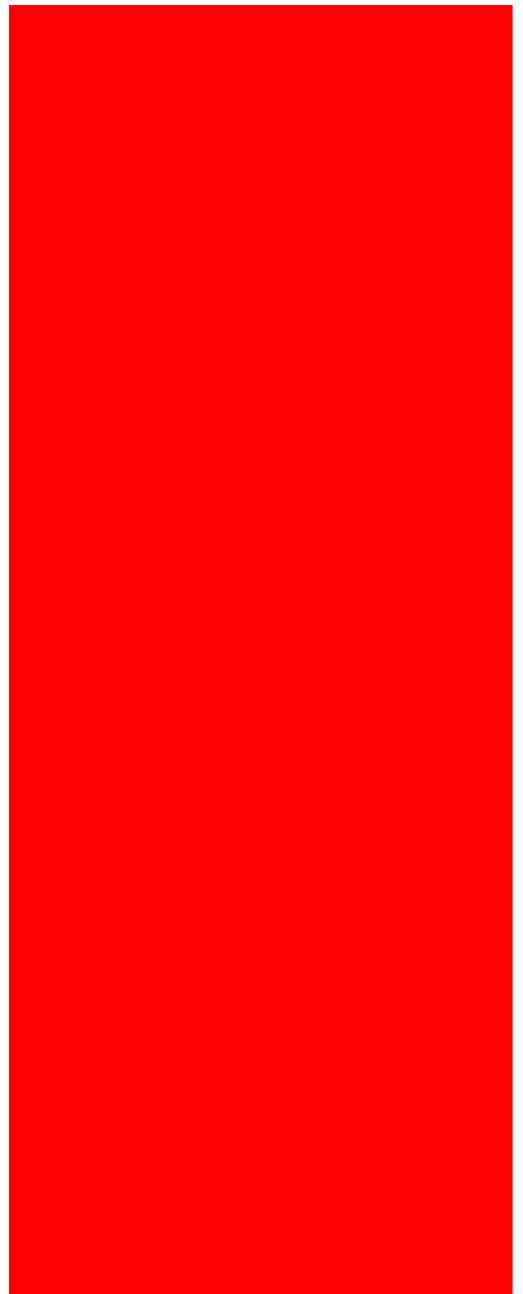
**2. Issue:** Roger continues to have seizures at least twice a week and is at risk of falling. **Plan:** Within one (1) business day of the assessment the BH CM will request a home nurse visit to educate Roger/Joyce and any care providers how to properly respond during seizures and how to administer Roger’s medications. The BH CM initiates contact with the PCP within one business day to coordinate review of medications, referral to a neurologist, and to obtain a referral for a home safety evaluation to be completed by a physical therapist to identify alternative adaptive aids. The SAFE Assessment Tool and CDC brochure are used to identify environmental hazards in the home that may contribute to his risk of injury due to falls. The BH CM will discuss safety aids with Joyce including; door and window alarms, low bed, and helmet to prevent injury from seizures or falls. **Desired Outcomes:** *Short-term* – Roger’s seizures will be adequately managed, relationships with care providers will be established and risk of injury from fall is reduced. *Long term* – Roger will be able to safely remain in his sister’s home.

**3. Issue:** Roger was receiving some undefined support services in the other state. Roger reports he is bored. **Plan:** The BH CM will ask Roger if he has any recall of the support services he received in the other state. The BH CM will review the medical records from the other state to see if they can determine the support services he received. The BH CM will discuss with Roger his interests and preferences for meaningful activities such as the TBI Adult Day program. The program specializes in providing activities and socialization for people with traumatic brain injury. Also, life skills training will be described. This program is designed to enhance independence and dignity. **Desired Outcomes:** *Short-term* – Roger will have the opportunity to engage in meaningful activities. *Long term* – Roger will remain living at home with his sister and acquire life skills.

**4. Issue:** Joyce is having difficulty managing Roger’s behaviors. **Plan:** If Joyce is unable to manage Roger safely at home and all other interventions have been unsuccessful, the BH CM will consult with the MCP Behavioral Health Placement Specialist within two (2) business day of assessment to determine the most appropriate and least restrictive setting to meet Roger’s needs. The BH CM informs Joyce there may be a financial responsibility associated with certain placement. The BH CM will assist Roger/Joyce in the transition to the selected facility. For continuity of care, MCP will attempt to keep Roger/Joyce assigned to the same BH CM. **Desired Outcomes:** *Short-term* – Roger will be safely transitioned to a facility of choice. *Long term* – Roger will reside in the least restrictive environment that meets his needs.

Medical Management

25.





## Question 25 – Medical Management

Mercy Care Plan (MCP), since 1984 has actively gathered, monitored, analyzed, and reported information relating to ALTCS members and their use of health care services. We gather accurate, timely, complete, and relevant information about the utilization patterns of ALTCS members. This has been a management focus of MCP because this information is vital to our ability to monitor and report on the status of our ALTCS membership. The Southwest Catholic Health Network (SCHN) Board of Directors (the Board) is MCP's governing body and is ultimately responsible for all aspects of the medical management program. The Board delegates authority to MCP's chief executive officer (CEO) to develop and administer the medical management program (including utilization management). The CEO delegates authority and responsibility to our Chief Medical Officer (CMO) to execute all aspects of our medical management program. Under the leadership of our CMO we have continually strengthened and improved our ability to gather, analyze, monitor/evaluate, and report utilization data to facilitate the delivery of appropriate care and services to our members. Throughout our process of collecting and managing utilization data we protect the privacy of our members and the security of our members' protected health information (PHI). MCP gathers, analyzes, evaluates/monitors, and reports utilization data to effectively manage and deliver medically necessary and covered services in the amount, intensity, and duration necessary to achieve improved health outcomes for our members across the continuum of care (from prevention to the end of life). Our goal is that the members receive the right service, at the right time, and at the right level of care/setting. MCP considers the collection of accurate, timely, and complete utilization data to be pivotal to our success to facilitate the delivery of appropriate care and services to our members. One of MCP's major sources of utilization data is claims and encounters data. These data are our most significant source of information for the evaluation/monitoring and reporting of utilization patterns. We augment claims data with prior authorization (PA) information, from both our PA Department and LTC case managers (CMs). One example of the value of PA information is our early warning respiratory report to indicate an increase in inpatient utilization that may be due to a flu outbreak. Both the claims data and encounters are treated the same by our Actuarial Services Data Base (ASDB) - our claims warehouse. ASDB supports MCP's reporting and analytical needs, such as our multidimensional predictive modeling and statistical outlier analysis. ASDB includes eligibility, provider, prior authorization, pharmacy, and claims data and serves as a key data source for medical management. Analysts from our Actuarial Services Department use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports; drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that provides MCP's leadership with access to member/provider cost and utilization trends.

MCP has developed a utilization management suite of 14 reports that provides MCP's leadership with a comprehensive set of information to examine utilization patterns and trends. Data from these reports are analyzed by our CMO during a weekly inter-department utilization management work group (hereinafter referred to as WIDUM) to determine potential over/under utilization. Of these 14 reports, there are six (6) key utilization reports that represent the core of the data we analyze. These reports are: 1) Category of Expense (COE); 2) PCP Initiative Report; 3) Inpatient Cost Report; 4) Pharmacy Utilization Report; 5) Inpatient Census Report; and 6) ED Cost Report. MCP has elected to include the COE (please see **Sample Report A**), the PCP Initiative (please see **Sample Report B**), and the Inpatient Cost Report (please see **Sample Report C**) in our proposal as representative utilization reports. The CMO's weekly WIDUM work group (including personnel from finance, operations, medical management, VP of Long Term Care, case management and other areas as necessary) is responsible for completing a comprehensive analysis of utilization data. This analysis identifies over/under utilization and/or unexpected trends. Drilling down into these data is an iterative process that often results in identification of multiple utilization variances. Our WIDUM work group's knowledge, expertise, and experience are invaluable in identifying and analyzing these variances. Outcomes from the CMO's WIDUM work group are shared with our Quality Improvement (QI) Committee, QM/UM Committee, and ultimately to the Board. The WIDUM is responsible for ascertaining root causes and developing recommendation for interventions to correct variances in unexpected or adverse utilization patterns that often impact our members' health outcomes and quality of care. The WIDUM work group's recommendations are submitted to the QM/UM Committee for consideration and approval. Often there is discussion between the WIDUM work group, QI Committee, as appropriate, and the QM/UM Committee to finalize the intervention strategies to improve quality and cost effectiveness across the continuum of care. We report utilization data internally - to communicate trends and identify member and or provider utilization patterns - to QM/UM and all appropriate departments including, but not limited to: member services, provider services, credentialing, case management, quality management, and finance. Utilization data is reported to our provider network and specifically to a provider or group of providers for specific problem-solving or developing corrective action plans. Additionally, utilization



data is reported to critical community organizations and AHCCCS. MCP has never been sanctioned for failure to deliver timely, complete, and accurate utilization reports. Utilization data and outcomes from the QM/UM Committee actions are reported to the Board. MCP has a comprehensive process for monitoring and evaluating under/over utilization of services. Based on outcomes from the process described above, MCP implemented the following interventions to address the over/under utilization variances. The goals of these interventions were to improve health outcomes, quality of care and cost effectiveness by promoting the availability of the right service, at the right time and the right level of care. Our member example illustrates both under/over utilization – under utilization of PCP appointments and over utilization of ED visits.

**Member Under/Over Utilization Example:** The QM/UM Committee identified an under utilization of PCP appointments as one of the primary contributors to high ED visits. The PCP initiative was designed to increase our ALTCS members' frequency of visits to their PCP. The goals of the initiative were to improve communication between the member and the member's family/caregiver<sup>1</sup> and the member's PCP, to promote the member's self-awareness of their health status, and to empower the member and the member's family/caregiver to ask the member's PCP questions about their condition and care. The CM has a major role in the PCP initiative. It is the responsibility of the CM, for their assigned caseload, to promote and increase PCP visits to at least quarterly. This responsibility is part of the CM annual assessment review and performance is part of the CMs' 1:1 meeting with their supervisor. The CM provides the member with a list of urgent care facilities within the member's residence zip code and educates the member and the member's family/caregiver on the appropriate use of the ED and urgent care centers. The CM verifies each quarter, during the in-home quarterly assessment process, that the member visited their PCP during the prior quarter; the member's record is updated CaseTrakker™ and in QNXT™ to track the member's progress. The QM/UM Committee identified ALTCS member over utilization of ED visits as a major problem and recommended a Patient Center Medical Home (PCMH) program to improve utilization management of our members with complex medical and bio-psycho-social conditions. Using our predictive modeling capabilities we identified members residing in institutions (e.g., NF, ALF) who were most at risk of frequent ED visits who have actionable gaps in care, or who presented opportunities for more efficient medical management consistent with evidence-based guidelines. The elements of the PCMH program that are to be available to these high risk members must include, but are not limited to: 1) each member must have a minimum of a monthly PCP visit; 2) the PCP must offer expanded hours and same day appointments; 3) the PCP is encouraged to have an electronic medical record with disease registry capabilities; 4) the PCP must agree to adhere to MCP Evidence-Based Clinical Practice Guidelines; and 5) the PCP must accept pay-for-performance incentives for specific AHCCCS performance measures. The PCMH model was originally offered as choice to those members residing in a NF or ALF. After an evaluation, the program was expanded as an offering for those members residing in their own home setting and who had frequent hospitalizations and ED visits and infrequent PCP appointments. Regardless of the member setting, the PCMH model includes the same components. If necessary, the PCP will make after hours or weekend visits to a member who has had a change of condition due to exacerbation of illness or recent admission. The CM was seen as vital to our PCMH intervention and has assumed an expanded role. As a result the CM developed an expanded and more inactive relationship with the member's PCP. In many instances, the CM involves a multi-disciplinary team to support those members and their PCP's if the pattern of ED utilization fails to improve. Please see sample Report B to review information of the increase of PCP appointments and the reduction of ED visits. Another intervention the QM/UM Committee recommended was a member and member family/caregiver and provider education campaign to focus on when visits to an ED was appropriate. We used data in ASDB to identify members with three or more emergency department visits during a three month period. Identified members were contacted via mail in an attempt to educate members about appropriate uses of emergency departments and potential alternatives such as the use of the member's primary care provider or an Urgent Care facility. In conjunction with these member education activities, MCP also notified providers when members on their panels appeared to excessively use emergency department services. During contract year 2010, 4,829 mailings were sent to members and 814 to providers regarding excessive ED utilization. After comprehensive analysis and evaluation of this intervention, the QM/UM Committee, in August 2010, recommended discontinuation of this intervention. Our QM/UM Committee, following discontinuation of this intervention, approved the CMO through an improved enhancement to ASDB, to modify the selection of at risk members for over utilization of ED and future adverse outcomes. Identified members were then assigned to our intensive RN driven CM team to receive a member-centered and highly individualized program designed to improve member health outcomes, quality of care and reduce avoidable ED utilization.

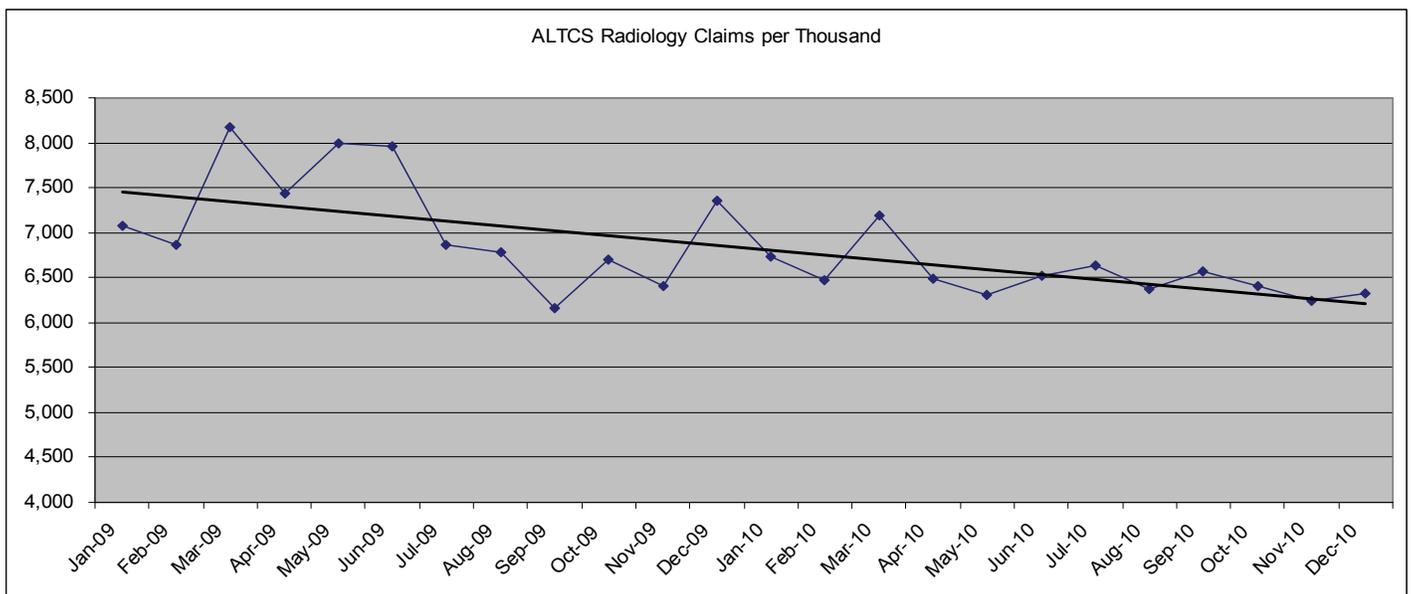
---

<sup>1</sup> Hereinafter, all references to "family/caregiver" include the member's guardian.



**Provider Under Utilization Example:** The QM/UM Committee identified that providers were failing to adhere to evidence based clinical practice guidelines (hereinafter referred to as EBCPG) for certain diseases. This pattern of under utilization was identified by a specialized contractor, ActiveHealth Management. They analyzed our historical medical and pharmacy claims experience, lab test results (when available) and determined we had an under utilization of statins in members at high risk for cardiovascular disease. The outcome of this analysis was the generation of a Care Consideration recommendation, mailed to the provider, member or the member’s family/care giver, and at the same time is made available to members’ assigned CM in CaseTrakker™. Our CMs address Care Considerations with members during the member’s quarterly assessment or as indicated. For each Care Consideration, CMs will provide additional education to the member and the member’s family/caregiver as needed. This includes encouraging members to discuss their medication regimen with their PCP. The value of Care Considerations improving PCP adherence to EBCPG was the PCP acceptance of the Care Consideration recommendation and the increase in statin utilization for ALTCS members from 47 scripts/thousand to 62 scripts/thousand. MCP’s recent provider satisfaction data indicates that over 61% of PCPs agreed with the member specific Care Considerations. These data indicate that PCP compliance with Care Considerations has increased from 29% to 42% (from 2009-2010). This experience indicates improved adherence to EBCPG through appropriate utilization of statins and increased optimized care for our members at risk for cardiovascular disease.

**Provider Over Utilization Example:** QM/UM Committee recognized an increase utilization pattern of radiology services in all settings (inpatient, radiology centers and physician offices). MCP recognized increased utilization of radiology service from providers, especially in physician practice sites, and developed intervention strategies to address these trends. The CMO’s WIDUM work group through analysis of claims data identified the adverse utilization trends and developed a comprehensive intervention strategy to address aberrant utilization patterns. The WIDUM work group identified high performing radiology providers that had a center of excellence approach to radiology management and would work cooperatively with the MCP and had sufficient capacity to deliver accessibility and availability of services. Furthermore, we amended the existing contracts with hospital providers and those physician practices that offered radiology services in the office setting by reducing the fee schedule for covered radiology services to reduce utilization trends at these sites. The CMO and designated medical directors identified and visited physician practices with a history of ordering radiology services that failed to adhere to EBCPG. The purpose of these visits was to educate providers regarding MCP EBCPG in an attempt to change practice patterns. The intent of these multi-faceted interventions was to target utilization that exceeded EBCPG without reducing access to medically necessary radiology services. The QM/UM Committee approved these interventions to assess best practices in 1) reduce unnecessary utilization; 2) control cost and 3) provide a geographically convenient flow of members among network providers. As indicated in the table below (data for this table were extracted from our February 2011 COE report) there has been a reduction in ALTCS radiology claims in the past two quarters. The CMO will continue to track and report on this intervention.





## Sample Utilization Reports

# Sample Report A - Category of Expense (COE) MCP ALTCS

## Rolling 12 Months Variance Report By Category of Expense

PMPMs from Jan-11 financials

Includes Most Recent Three (Noncredible) Months

**Triggers**

PMPM Trend Contribution	2%
PMPM Trend	10%
Utilization Trend	10%
Unit Cost Trend	10%

Units	PMPM		Trend Contribution		Util per 1,000		Unit Cost	
	12 Months Ending Jan-11	12 Months Ending Jan-10	PMPM	%	12 Months Ending Jan-11	12 Months Ending Jan-10	12 Months Ending Jan-11	12 Months Ending Jan-10
Inpatient Facility	224.89	210.48	14.41	0.2%	776.6	782.2	3,474.91	3,228.93
Mental Health Inpatient	6.51	5.70	0.82	0.0%	12.1	17.5	6,445.90	3,903.80
Emergency	14.52	14.15	0.37	0.0%	869.9	894.3	200.28	189.82
Selected Ambulatory Facility	48.56	53.34	-4.79	-0.1%	4,049.7	3,587.0	143.88	178.45
Mental Health Non-Inpatient	20.47	17.29	3.18	0.0%	2,273.1	2,167.7	108.06	95.74
Primary Physician	12.52	11.87	0.65	0.0%	3,993.9	3,833.0	37.62	37.16
Specialist Physician	101.85	99.93	1.91	0.0%	24,580.8	23,885.3	49.72	50.21
Home Health	52.55	49.29	3.26	0.0%	52,135.6	55,689.9	12.10	10.62
Laboratory	3.44	4.38	-0.94	0.0%	4,540.1	14,274.8	9.09	3.68
Medical Pharmacy	8.98	9.12	-0.13	0.0%	120,037.9	139,548.1	0.90	0.78
Misc. Medical	120.15	115.29	4.86	0.1%	256,029.2	234,834.1	5.63	5.89
Radiology	15.57	18.26	-2.69	0.0%	6,394.9	7,115.0	29.22	30.80
Community Based Svcs	1,971.80	2,068.87	-87.06	-1.0%	336,159.3	359,142.9	70.39	68.79
Home Based Svcs	1,482.44	1,499.78	-17.34	-0.2%	4,418,319.8	4,326,208.1	4.03	4.16
Institutional	4,017.88	4,048.20	-30.32	-0.4%	366,569.8	344,651.4	131.53	140.95
Retail Rx	110.06	100.14	9.92	0.1%	20,698.0	18,795.8	63.81	63.94
<b>Total</b>	<b>8,212.20</b>	<b>8,316.09</b>	<b>-103.88</b>	<b>-1.2%</b>	<b>5,617,441</b>	<b>5,535,427</b>	<b>17.54</b>	<b>18.03</b>

Units	PMPM		Trend Contribution		Util per 1,000		Unit Cost	
	Current Year	Previous Year	PMPM	%	Current Year	Previous Year	Current Year	Previous Year
ICU/CCU - IP Facility	161.99	148.61	13.38	-12.9%	505.9	507.3	3,842.76	3,514.99
Retail Rx - Brand-SS	61.46	56.42	5.04	-4.9%	2,622.5	2,493.5	281.21	271.51
Retail Rx - Generic	40.73	35.93	4.79	-4.6%	17,011.3	15,319.3	28.73	28.15
Surgery, IP - IP Facility	43.23	39.07	4.16	-4.0%	215.8	197.6	2,403.77	2,372.63
Ambulance/Transportation - Other Prof	61.92	58.55	3.37	-3.2%	184,078.9	170,156.9	4.04	4.13
<b>Total</b>	<b>369.32</b>	<b>338.58</b>	<b>30.74</b>	<b>-29.6%</b>	<b>184,078.9</b>	<b>170,156.9</b>	<b>4.04</b>	<b>4.13</b>

### Top 5

ICU/CCU - IP Facility	Admits	161.99	148.61	9.0%	13.38	-12.9%	505.9	507.3	-0.3%	3,842.76	3,514.99	9.3%
Retail Rx - Brand-SS	Serv Units	61.46	56.42	8.9%	5.04	-4.9%	2,622.5	2,493.5	5.2%	281.21	271.51	3.6%
Retail Rx - Generic	Serv Units	40.73	35.93	13.3%	4.79	-4.6%	17,011.3	15,319.3	11.0%	28.73	28.15	2.1%
Surgery, IP - IP Facility	Admits	43.23	39.07	10.6%	4.16	-4.0%	215.8	197.6	9.2%	2,403.77	2,372.63	1.3%
Ambulance/Transportation - Other Prof	Serv Units	61.92	58.55	5.8%	3.37	-3.2%	184,078.9	170,156.9	8.2%	4.04	4.13	-2.2%

### Bottom 5

Dialysis/ESRD - Other Facility	Visits	17.42	24.62	-29.2%	-7.19	6.9%	2,261.4	1,792.2	26.2%	92.45	164.82	-43.9%
Routine - IP Facility	Admits	14.76	19.05	-22.5%	-4.29	4.1%	50.2	72.0	-30.3%	3,528.70	3,173.72	11.2%
Radiology - Prof Physician	Serv Units	7.37	9.42	-21.8%	-2.05	2.0%	4,796.3	5,335.1	-10.1%	18.43	21.19	-13.0%
Chemotherapy - Other Prof	Serv Units	3.41	4.91	-30.6%	-1.50	1.4%	3,205.3	3,390.7	-5.5%	12.75	17.38	-26.6%
Laboratory - Prof Physician	Serv Units	1.00	2.36	-57.6%	-1.36	1.3%	2,313.0	10,928.6	-78.8%	5.20	2.60	100.3%
<b>Total</b>		<b>43.96</b>	<b>60.36</b>	<b>-27.2%</b>	<b>-16.40</b>	<b>15.8%</b>						

## Sample Report B: PCP Initiative

### PCP Initiative Reports

(PCP Initiative Quarter to Quarter Comparison)

PCP Initiative Measurement	4 Q 2010	3 Q 2010	2 Q 2010	1 Q 2010	4 Q 2010	3 Q 2009	2 Q 2010
<i>Percentage of members with Quarterly PCP visits</i>	77	75	76	77	78	64	61

(Number of Members Due for a Quarterly PCP Visit compared to the Number with PCP Visit)

Jan - March 2010	
Base # Members	5724
No recorded visit	1289
Recorded Visit	4435
Total Percent	77.48%

Plan: AZ - Arizona Long Term Care System  
 Paid through: Feb-11

	Dec-08 to Nov-09	Dec-09 to Nov-10	Trend
Paid PMPM	\$ 215.53	\$ 230.03	6.7%
MemberMonths	100,139.87	101,226.74	1.1%
Days/1000	3,228	3,430	6.3%
Cost/Day	\$ 801.33	\$ 804.89	0.4%
Unit Price			11.4%
Bed Type Mix			-5.3%
Provider Mix			-5.6%

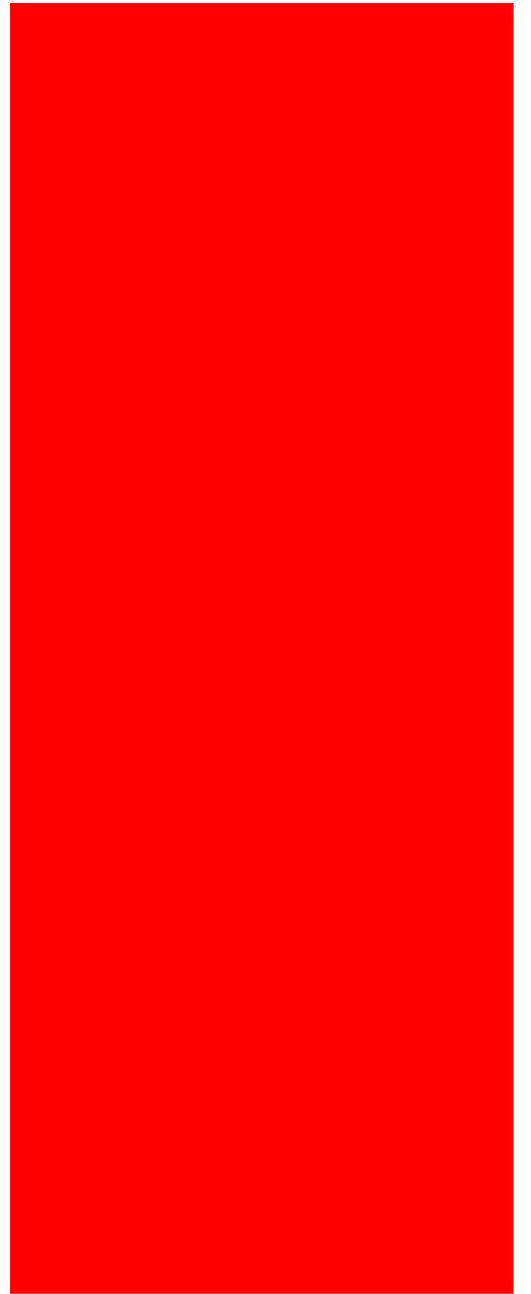
Services																
Bed Type	Dec-08 to Nov-09					Dec-09 to Nov-10					Trend					
	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	
ICU/CCU	2,013	318	6.3	\$ 891	\$ 5,632	1,916	312	6.1	\$ 999	\$ 6,135	-5%	-2%	-3%	12%	9%	
Surgery, IP	618	133	4.6	\$ 736	\$ 3,416	655	138	4.8	\$ 785	\$ 3,739	6%	3%	3%	7%	9%	
Routine	316	44	7.1	\$ 718	\$ 5,112	217	28	7.7	\$ 822	\$ 6,364	-32%	-37%	9%	14%	24%	
Psych/Detox	197	11	18.1	\$ 304	\$ 5,493	196	12	16.4	\$ 489	\$ 8,007	-1%	10%	-9%	61%	46%	
Rehab	70	3	20.0	\$ 619	\$ 12,387	58	4	15.7	\$ 880	\$ 13,857	-17%	6%	-21%	42%	12%	
Other IP Facility	11	2	7.2	\$ 65	\$ 468	385	17	22.4	\$ 14	\$ 323	3315%	1003%	210%	-78%	-31%	
Maternity	0	0	2.0	\$ 13,662	\$ 27,324	1	0	2.7	\$ 667	\$ 1,780	98%	48%	33%	-95%	-93%	
Substance Abuse	1	0	4.5	\$ 122	\$ 548	2	0	3.8	\$ 229	\$ 859	65%	98%	-17%	88%	57%	
<b>Grand Total</b>	<b>3,228</b>	<b>513</b>	<b>6.7</b>	<b>\$ 801</b>	<b>\$ 5,045</b>	<b>3,430</b>	<b>511</b>	<b>6.7</b>	<b>\$ 805</b>	<b>\$ 5,399</b>	<b>6%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>7%</b>	

1 Day Stays, % Admits via ED, Avoidable Admissions																
Metric	Dec-08 to Nov-09					Dec-09 to Nov-10					Trend					
	Admits/1000	% of Total Admits	LOS	Cost/Day	Cost/Admit	Admits/1000	% of Total Admits	LOS	Cost/Day	Cost/Admit	Admits/1000	% of Total Admits	LOS	Cost/Day	Cost/Admit	
1 Day Stays	50	9.8%	1.0	\$ 2,540	\$ 2,540	52	10.2%	1.0	\$ 2,465	\$ 2,465	3%	4%	0%	-3%	-3%	
Admits via ED	417	81.3%	5.5	\$ 764	\$ 4,228	387	75.7%	5.5	\$ 816	\$ 4,479	-7%	-7%	-1%	7%	6%	
Avoidable Admits	177	34.6%	4.8	\$ 730	\$ 3,523	165	32.2%	4.8	\$ 792	\$ 3,783	-7%	-7%	-1%	8%	7%	

Top 5 DX Categories																
DX Category	Dec-08 to Nov-09					Dec-09 to Nov-10					Trend					
	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	
01-Respiratory Disorders	584	83	7.0	\$ 904	\$ 6,329	547	84	6.5	\$ 940	\$ 6,151	-6%	0%	-7%	4%	-3%	
02-Cardiac Disorders	308	70	4.4	\$ 956	\$ 4,235	296	65	4.6	\$ 1,053	\$ 4,795	-4%	-6%	3%	10%	13%	
03-Digestive Disorders	338	61	5.5	\$ 796	\$ 4,411	352	60	5.9	\$ 700	\$ 4,135	4%	-2%	7%	-12%	-6%	
04-Nonspecific Disorders	282	40	7.1	\$ 644	\$ 4,562	298	44	6.8	\$ 752	\$ 5,079	6%	11%	-5%	17%	11%	
05-Infectious Disease	278	32	8.6	\$ 984	\$ 8,482	215	31	7.0	\$ 954	\$ 6,708	-23%	-5%	-18%	-3%	-21%	
<b>Grand Total</b>	<b>1,790</b>	<b>286</b>	<b>6.3</b>	<b>\$ 864</b>	<b>\$ 5,408</b>	<b>1,708</b>	<b>283</b>	<b>6.0</b>	<b>\$ 879</b>	<b>\$ 5,307</b>	<b>-5%</b>	<b>-1%</b>	<b>-4%</b>	<b>2%</b>	<b>-2%</b>	

Member Risk Groups																
Risk Group*	Dec-08 to Nov-09					Dec-09 to Nov-10					Trend					
	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	Days/1000	Admits/1000	LOS	Cost/Day	Cost/Admit	
High	1,141	192	5.9	\$ 848	\$ 5,033	2,301	331	6.9	\$ 806	\$ 5,599	102%	72%	17%	-5%	11%	
Medium	197	40	5.0	\$ 794	\$ 3,959	166	32	5.1	\$ 599	\$ 3,081	-16%	-18%	3%	-24%	-22%	
Low	392	67	5.9	\$ 679	\$ 3,981	132	28	4.8	\$ 663	\$ 3,154	-66%	-58%	-19%	-2%	-21%	
<b>Grand Total</b>	<b>1,731</b>	<b>299</b>	<b>5.8</b>	<b>\$ 804</b>	<b>\$ 4,655</b>	<b>2,600</b>	<b>391</b>	<b>6.6</b>	<b>\$ 785</b>	<b>\$ 5,216</b>	<b>50%</b>	<b>31%</b>	<b>15%</b>	<b>-2%</b>	<b>12%</b>	

26.



## Question 26 – Medical Management

Mercy Care Plan (MCP), since 1984 has actively gathered, monitored, analyzed, and applied data to identify opportunities to improve health outcomes for our members and identify and correct unfavorable utilization patterns. We routinely gather accurate, timely, and relevant information about favorable and unfavorable utilization patterns of ALTCS members. MCP focuses on gathering and analyzing data to determine favorable and unfavorable utilization patterns because this information is vital to our ability to successfully develop interventions to improve health outcomes and quality of care by modifying unfavorable utilization patterns. The Southwest Catholic Health Network (SCHN) Board of Directors (the Board) is MCP’s governing body and is ultimately responsible for all aspects of our medical management program. The Board delegates authority to MCP’s chief executive officer (CEO) to develop and administer the medical management program (including utilization management). The CEO delegates authority and responsibility to our chief medical officer (CMO) to execute all aspects of our medical management program. Under the leadership of our CMO we have continually strengthened and improved our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care, and alter unfavorable utilization patterns.

MCP considers the collection of accurate, timely, and complete utilization data and results of clinical performance measures to be pivotal to developing successful interventions to improve health outcomes and quality of care, and correct unfavorable utilization patterns. Our CMO convenes a weekly inter-departmental work group (including personnel from Finance, Operations, Medical Management, Long Term Care, Case Management) that is responsible for the comprehensive analysis of utilization data. This analysis identifies over/under utilization and/or unexpected trends that may impact health outcomes and quality of care. This internal work group, working closely with actuarial services (informatics unit) drills down into the complexities of these data, identifies potential root causes and potential interventions. Drilling down into these data is an iterative process that often results in identification of multiple variances in utilization. Our cross-functional, inter-departmental work group’s knowledge, expertise, and experience are invaluable in the analysis of these variances and the identification of unfavorable utilization patterns that require interventions. This information is shared with the Quality Improvement (QI) Committee. The QI Committee is responsible for ascertaining root causes and developing recommendations for interventions [e.g., Performance Improvement Plans (PIPs)] to correct variances in unexpected or adverse utilization patterns that often impact health outcomes and quality of care. The QI Committee’s recommendations are submitted to the QM/UM Committee for consideration and approval. Often there is discussion between the QI Committee and the QM/UM Committee to finalize the intervention strategies to improve quality and cost effectiveness across the continuum of care. This process is how we identified the unfavorable utilization patterns of higher than expected avoidable hospital admissions and Average Length of Stay (ALOS), and higher ED utilization combined with under utilization of PCP visits for the ALTCS population.

ALTCS members have complex and multiple chronic conditions along with dynamic cultural and health literacy factors that require innovative and comprehensive approaches to address unfavorable utilization. Our QM/UM Committee recommended a multi-faceted intervention approach as the best method for addressing unfavorable utilization patterns – our experience is that a single intervention approach is inadequate due to the array of services and care required by our members. Therefore, MCP developed a unique, innovative set of interventions. These interventions were designed to target both members and providers and to improve quality of care and health outcomes. Our underlying goal in the development, implementation, and monitoring of these interventions was to provide the member with the right service, at the right time, in the right setting. At each step of the intervention process, MCP applied the Plan-Do-Study-Act (PDSA) approach to fine-tune our interventions.

### Intervention Strategies

The QM/UM committee approved the implementation of multiple interventions to address the related adverse utilization of higher than expected avoidable hospital admissions and average length of stay (ALOS), and higher ED utilization combined with under utilization of PCP visits for the ALTCS population. Each intervention strategy was designed to address certain aspects of provider and member communication, behavior, understanding or approach to the decision-making that each member, the members’ family/caregivers<sup>6</sup>, and providers make to influence health outcomes and quality of care and utilization of services. These strategies included development and implementation of: 1) a Patient Centered Medical Home (PCMH) approach for the highest risk members in nursing facilities (NF), assisted living facilities (ALF), and in the members’ home; 2) a (Long Term Care) Case Manager (CM) initiative for all ALTCS members; 3) a

---

<sup>6</sup> Hereinafter, all references to “family/caregiver” include the member’s guardian

concurrent review discharge planning process by creating a member-centered discharge team to include the current review nurse and member CM; and 4) of a readmission prevention program. These intervention strategies are discussed below.

### ***Patient-Centered Medical Home (PCMH)***

The QM/UM Committee recognized that those members at the highest risk for hospitalization and ED utilization would benefit from a PCMH. Using our predictive modeling capabilities we identified members residing in institutions (e.g., NF, ALF) who were most at risk of a hospital admission, extended ALOS, and frequent ED visits who have actionable gaps in care, or who presented opportunities for more efficient medical management consistent with evidence-based guidelines. We designed a flexible PCMH program for these members that would be effective in addressing members in multiple settings. The elements of the PCMH that are to be available to these high risk members must include, but are not limited to: 1) each member must have a minimum of a monthly PCP visit; 2) the PCP must offer expanded hours and same day appointments; 3) the PCP is encouraged to have an electronic medical record with disease registry capabilities; 4) the PCP must agree to adhere to MCP Evidence-Based Clinical Practice Guidelines; and 5) the PCP must accept pay-for-performance incentives for specific AHCCCS performance measures. The PCMH model was originally offered as choice to those members residing in a NF or ALF. If the member chooses to participate in this program, the PCP will visit the member at the facility monthly and coordinate all aspects of the members care. This program was expanded as an offering for those members residing in their own home setting and who had frequent hospitalizations and ED visits and infrequent PCP appointments. Regardless of the member setting, the PCMH model includes the same components. If necessary, the PCP will make after hours or weekend visits to a member who has had a change of condition due to exacerbation of illness or recent admission. The CM was seen as vital to our PCMH intervention and has assumed an expanded role. The CM has an expanded and more direct relationship with the member's PCP. In many instances, the CM involves a multi-disciplinary team to support those members and their PCP's if the pattern of hospital admissions and ED utilization fails to improve.

### ***PCP Initiative***

The PCP initiative was designed to increase all ALTCS members' frequency of visits to their PCP. The goal of the program is for members to visit their PCP at least quarterly. The purpose of increased PCP visits is to improve communication between the member and the member's family/caregiver and the member's PCP, promote member self-awareness of their health status, and empower the member and the member's family/caregiver to ask questions to the PCP about their condition and care.

The ALTCS CM has a major role in the PCP initiative. It is the responsibility of the CM to promote and increase PCP visits to at least quarterly for their assigned members. This responsibility is part of the CM annual assessment review and performance is part of the CM routine 1:1 meeting with their supervisor. At each in-home quarterly assessment, the CM provides the member with an updated PCP initiative checklist. The checklist is updated each quarter to include new or continuing issues the member should discuss with their PCP at the next PCP appointment. In addition, the CM includes a copy of the member's updated medication history to bring with them to their next PCP appointment. If appropriate, the CM assists the member and the member's family/caregiver with scheduling the next PCP appointment and transportation. The CM provides the member with a list of urgent care facilities within the member's residence zip code and educates the member and the member's family/caregiver on the appropriate use of the ED and urgent care centers. The CM verifies that the member visited their PCP during the prior quarter. The CM documents results of each in-home quarterly assessment in both CaseTrakker™ and in QNXT™ to track the member's progress.

### ***Improved Discharge Planning Process***

The QM/UM Committee recognized the need to improve discharge planning for hospitalized members. Due to the medical, behavioral, psycho-social and placement challenges of our members, it is imperative that discharge planning be holistic, member-centered and proactive. Therefore, the CMO formed an innovative approach to discharge planning by bringing together the concurrent review nurse and the member's CM. Both the concurrent review nurse and the CM have access to QNXT™ data for member's claims, prior authorization, pharmacy data, and case management notes regarding the member and the member's care plan from CaseTrakker™. Bringing together these two unique perspectives is a powerful tool to support the member during and after hospital discharge. It is our experience that the transition from the hospital to the member's placement/residence is often complex, demanding, and difficult for the member. MCP's discharge planning approach is to bridge these complexities, demands, and difficulties by directly involving the member, the member's family/caregiver, the member's PCP, the concurrent review nurse, and the CM in all aspects of discharge planning. In this way, the member and the member's family/caregiver are aware, engaged in, and fully prepared for the transition.

### Readmission Prevention Program

The QM/UM Committee recognized that for many of our most complex members with multiple co morbid conditions, who are discharged to home are often are readmitted to the hospital within 30 days. This pattern results in reduced health outcomes, quality of care, increased utilization, and negatively impacts the member’s quality of life. Therefore, the CMO developed a high-intensity, comprehensive, holistic and member-centered clinical CM program to supplement the standard CM program. CMs in this program are all RNs with extensive experience working with the elderly and physically disabled. This readmission prevention program includes the following activities: 1) on-site assessment by the CM at the hospital; 2) in-home visit within 48 hours of discharge for assessment of: a) medication reconciliation; b) DME and home healthcare services as ordered; c) home/family support; d) level of functional screening of physical, cognitive, and behavioral factors; 3) in home or telephonic assessments at 3, 6, 10 and 14 days post discharge; 4) 30 days post discharge assessment of the member to determine if the member’s post discharge needs have been met. This voluntary program includes close and constant communication during this critical period between the clinical CM and the member’s assigned CM. Currently, this program is in effect at four hospitals. The CMO, reporting to the QM/UM Committee, is evaluating the effectiveness of this program for expansion to other hospitals.

### Reporting and Assessment

The results of these interventions are presented to the QM/UM to continue the cross-functional and inter-departmental collaboration necessary to develop this multi-faceted approach and to assess and evaluate the effectiveness of each intervention. The QM/UM committee recommends modifications and adjustments to the interventions to improve health outcomes and quality of care and to reduce the impact of these adverse utilization trends. At each step of these interventions, the QM/UM committee determines if progress has been made in providing the member with the right service, at the right time, in the right level of care.

### Intervention Results

The QM/UM Committee reviews and analyzes data (from actuarial services) to determine the effectiveness of the interventions. As a result of this analysis, MCP is pleased to report that the interventions have been successful in reducing hospital admissions, ALOS, ED utilization and increasing PCP visits.

Metrics	2007	2008	2009	2010	Year to Year Change	2008	2009	2010	2yr
									2008 -> 2010
ER Visits/K	838	894	903	873	ER Visits/K	6.7%	1.0%	-3.3%	-2.4%
IP Admits/K	750	845	770	781	IP Admits/K	12.7%	-8.9%	1.5%	-7.6%
IP Days/K	4,580	5,182	4,421	4,269	IP Days/K	13.1%	-14.7%	-3.5%	-17.6%
IP ALOS	6.1	6.1	5.7	5.5	IP ALOS	0.4%	-6.3%	-4.9%	-10.9%
MM	99,776	98,937	100,681	101,888	MM	-0.8%	1.8%	1.2%	3.0%

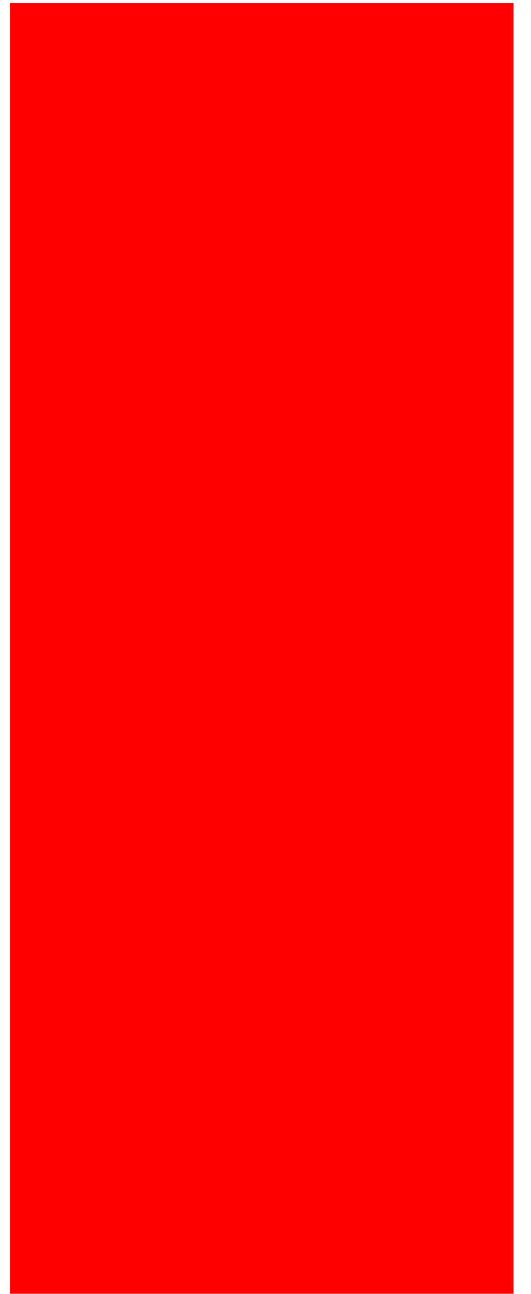
Measure	2008	2009	2010
% of ALTCS members w Quarterly PCP visit	61	68	77

### Altering Unfavorable Utilization Patterns

MCP identified, through the analysis of utilization and clinical performance measures, unfavorable utilization trends in inpatient hospitalization, ALOS, and ED with the corresponding underutilization of PCP visits. Working with the cross-functional and inter-departmental QM/UM committee, the CMO developed innovative and comprehensive multi-faceted interventions to address these unfavorable utilization patterns. Our interventions were developed and implemented to alter these unfavorable utilization patterns. Each intervention strategy has been monitored independently and the combined impact has also been assessed. Subsequent analysis, post intervention assessment, and continual evaluations were aimed at determining effectiveness of each intervention. It is through our consistent and applied analysis of data that we identified the necessary intervention approaches and allowed MCP to continually adjust and revise intervention strategies.

An analysis of the data and tables above clearly indicate that the interventions produced an alteration of unfavorable utilization patterns. The purpose of our program and process to gather, analyze, monitor/evaluate, and report utilization data is to identify cost effective and efficient interventions that can result in improved quality of care and health outcomes for our members. Our data, in the tables above, demonstrates the effectiveness of these interventions in decreasing utilization in hospital admissions, ALOS, and ED visits. Furthermore, we had positive impact on increasing the percentage of members with quarterly PCP visits year over year. By altering these unfavorable utilization patterns, MCP improved health outcomes, quality of care and provided the member with the right service, at the right time, in the right level of care.

*27.*



### Question 27 – Medical Management

Mercy Care Plan’s (MCP’s) goal is to positively impact the health status of our members through an integrated and coordinated Chronic Care/Disease Management program. MCP implemented its first Chronic Care/Disease Management program in 2000 and has continuously improved and enhanced our programs to: 1) positively impact our members’ health outcomes and quality of care; 2) support the member in the least restrictive setting; and 3) improve our providers’ practice patterns and compliance with Evidence-Based Clinical Practice Guidelines. MCP’s program integrates physical health, behavioral health (BH), long term care services, disease management and community-based services through an intensive member-centered case management program. Our comprehensive program is designed to enhance the quality of life, improve health outcomes, and achieve and/or maintain the highest level of self-sufficiency for our members. Southwest Catholic Health Network (SCHN) Board of Directors (the Board) is responsible for the MCP’s Chronic Care/Disease Management program. The Board delegates responsibility to the Chief Executive Officer (CEO), who delegates the day-to-day administration of the Chronic Care/Disease Management program to the Chief Medical Officer (CMO). The CMO is supported by the Case Management Administrator/Manager, VP of Quality Management (QM), VP of Utilization Management, Director of Integrated Case Management, and the QM/UM Committee. The QM/UM Committee is critical to our Chronic Care/Disease Management program. The CMO makes recommendations to the QM/UM Committee regarding disease conditions to be included in the Chronic Care/Disease Management program based on the prevalence of high cost/high volume conditions within our membership and utilization patterns. The QM/UM Committee continually evaluates, reviews, and makes modifications to the chronic care/disease management program. It is MCP’s experience that Chronic Care/Disease Management programs increase their effectiveness when the members and providers are educated and informed about the scope and depth of the programs. Members receive information about MCP’s Chronic Care/Disease Management programs at time of enrollment and continually through other sources (e.g., Website, Newsletters). Providers receive information during new contractor orientation and through other sources (e.g., Web Portal, Provider Newsletters). MCP uses the following communication tools to inform our members and providers about our Chronic Care/Disease Management program:

Member Communication	Provider Communication
Member Website	Provider Web Portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Team	Provider Services Representative
Care Plan	Care Plan
Member Call Center (Toll free call)	Provider Service Center
UM/PA – Notice of Action Letter	UM/PA – Service Approvals/Denials

Risk stratification is a key component of MCP’s Chronic Care/Disease Management program. MCP has successfully used risk stratification to maximize the effectiveness of our Chronic Care/Disease Management program by identifying members with the greatest opportunity for improvement (e.g., highest risk, highest cost, and experiencing poor health outcomes based on their condition). We also include members from a referral by either the: a) member’s Primary Care Physician (PCP); b) member or the member’s family/caregiver<sup>7</sup>; c) the member’s assigned Case Manager (CM); or d) other MCP personnel [e.g., quality management, utilization management (prior authorization or concurrent review), member services, or grievance and appeals]. Member education includes targeted member-specific educational mailings, quarterly education mailings, individual member health profile, and a website with access to searchable data for additional information and education. We report the effectiveness of our process to the QM/UM Committee.

### Disease Management Program

MCP’s disease management program is provided by Schaller Anderson of Arizona LLC (Schaller) as part of a management agreement. Schaller has been successfully operating disease management programs since 1993. Schaller has operated an NCQA certified disease management program for targeted chronic diseases (e.g., congestive heart failure, chronic obstructive pulmonary disease, depression, asthma, and diabetes) since 2006. The interventions for these targeted chronic diseases are based on Evidence-Based Clinical Practice Guidelines. It is MCP’s experience that applying a disease management approach to ALTCS members often results in improved health outcomes and quality of care.

<sup>7</sup> Hereinafter, all references to “family/caregiver” include the member’s guardian

Schaller’s Disease Management (DM) program emphasizes self-management support and member and member family/caregiver education improving healthcare outcomes for members. The program goals are: 1) increase the number of members using their medications correctly; 2) reduce morbidity and mortality of the disease; 3) decrease the incidence of ED visits and hospital admissions/length of stay; 4) engage the member and the member’s family/caregiver in maintaining a member’s wellness in the most integrated setting; 5) based on the member’s functional level, teach self-management skills; and 6) to support both the member and the PCP/provider in establishing a consistent relationship that improves adherence to the members’ care plan.

Schaller’s DM program also focuses on providers and includes specific program elements for: 1) education of PCPs/providers regarding Evidence-Based Clinical Practice Guidelines and that adherence to these guidelines improves members’ health outcomes; 2) the PCP/providers to be involved in the implementation and evaluation of the program, including through our QM/UM Committee; 3) monitoring PCPs/providers compliance with the Evidence-Based Clinical Practice Guidelines; 4) methods to improve PCPs/providers compliance with Evidence-Based Clinical Practice Guidelines, including but not limited to, corrective action plans or individualized training with QM RN personnel, CMO, or designee.

Our voluntary comprehensive DM program includes the following: 1) reviewing the member’s care plan in CaseTrakker™ to identify the results of the member assessment to include the member’s bio-psycho-social needs; 2) collaborating with the member and the member’s family/caregiver to identify the member’s goals for management of their disease/condition, quality of life expectations, and interventions founded on evidence-based guidelines to support those goals; 3) teaming with the member, and member’s family/caregiver, assigned CM, and key providers (e.g., PCP, BH provider) to identify the member’s needs and strengths implement successful interventions founded on evidence-based clinical guidelines and eliminate any barriers to care; 4) developing a care plan to address the member’s critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management with specific member outcomes; 5) educating members about their chronic disease and effective tools for self-management and evaluating the effectiveness of this member education as it relates to the members’ self-management of their disease; 6) promoting access to a continuum of services, including community services, based on the intensity and complexity of the member’s needs; 7) monitoring member outcomes to assess the program’s effectiveness; and 8) keeping the member’s PCP informed about the member’s enrollment in the Disease Management program and the disease management activities and outcomes.

MCP conducted an outcome analysis of Schaller’s DM program for PCP visits and ED visits. We compared pre- and post-enrollment for members who were enrolled in our disease management program between 1/1/2007 and 9/30/2009. We found that ED and PCP visits, along with per member per month expenditures, were consistently lower for all three measurement years after members enrolled in our disease management program.

MCP	CHF		COPD		Diabetes	
2009	Pre DM	Post DM	Pre DM	Post DM	Pre DM	Post DM
ER visits /member	2.4	0.5	4	1.2	4.2	1.1
PCP visits /member	3.2	1.2	4.3	1	4.1	1.6

### Active Health’s CareEngine® System and Care Considerations

The CareEngine® System is designed to support disease management by increasing members’ and PCPs’ adherence to Evidence-Based Clinical Practice Guidelines, improving the quality of healthcare for members and decreasing medical costs. The CareEngine® System accomplishes these goals through: 1) using historic and current medical and pharmacy claims, and lab test results data to develop member-centered records; 2) comparing the member data to existing clinical rules and algorithms, developed by Active Health’s team of board certified physicians and pharmacists; and 3) identifying member-specific opportunities to optimize care and communicate evidence-based treatment recommendations to providers. The outcome of this analysis is the generation of a Care Consideration recommendation, mailed to the member or the member’s family/care giver and at the same time is made available to members’ assigned CM in CaseTrakker™. Our CMs address Care Considerations with members during the member’s quarterly assessment or as indicated. For each Care Consideration, CMs will provide additional education to the member and the member’s family/caregiver as needed. This includes encouraging members to discuss the identified issue with their PCP. In addition, the member’s PCP receives clinical Care Considerations via a telephone call or mail, depending on severity. Clinical Care Considerations serve as alerts to PCPs regarding potential gaps in a members’ care and adherence opportunities to Evidence-Based Clinical Practice Guidelines. MCP’s recent provider satisfaction data indicates that over 61% of PCPs agreed with the

member specific Care Considerations. These data indicate that PCP compliance with Care Considerations has increased from 29% to 42% (from 2009-2010). An example of the value of Care Considerations in improving PCP adherence to Evidence-Based Clinical Practice Guidelines is that when PCPs were alerted that statins were recommended for members with a high risk for cardiovascular events, PCP accepted the recommendation and statin utilization for ALTCS members increased from 47 scripts/thousand to 62 scripts/thousand. This experience indicates improved adherence to Evidence-Based Clinical Practice Guidelines and increased optimized care for our members at risk for cardiovascular disease.

### **Chronic Care Programs**

It is our experience that most of our ALTCS members with chronic illnesses require care from several providers. This makes their care more challenging to coordinate. MCP has multiple chronic care programs to serve our members with complex medical and bio-psycho-social needs. These programs are based on Evidence Based Clinical Practice Guidelines (EBCPG) and are designed to improve health outcomes and quality of care in the most integrated setting. Our approach is to reduce inappropriate or avoidable use of services (e.g., inpatient admission and readmissions) by reducing barriers to a member's ability to self-manage their medical conditions. MCP has adopted a range of EBCPGs that are consistently reviewed and updated. Our QM/UM Committee annually reviews, analyzes, and approves our EBCPGs. This committee is chaired by our chief medical officer (CMO) and membership includes PCPs, specialists, and BH providers. The CM, member, member's family/caregiver, and PCP each play integral roles in the chronic care programs.

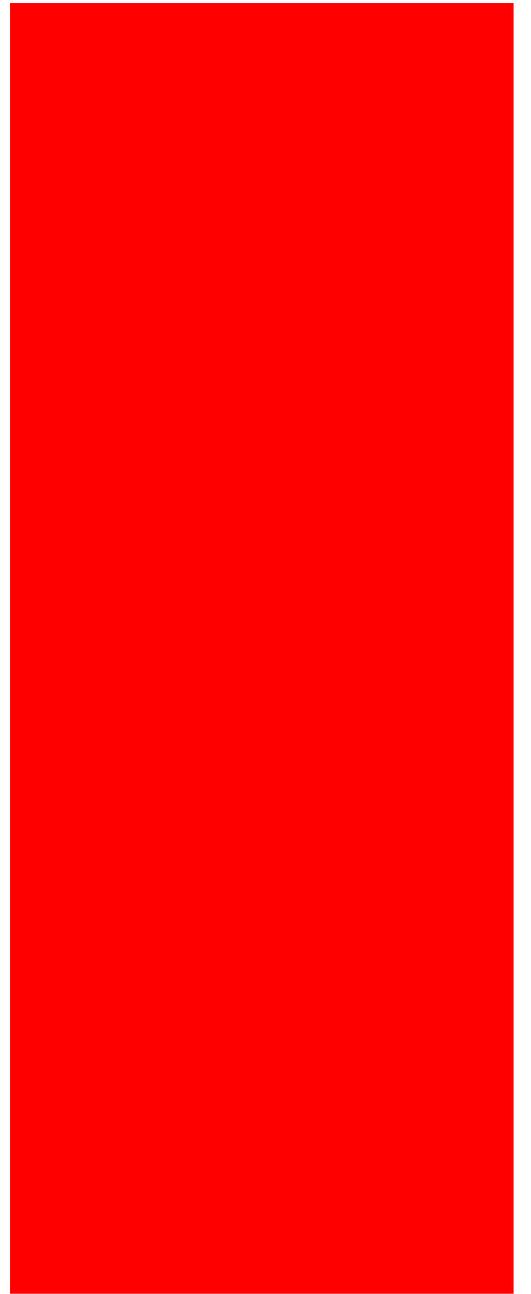
It is MCP's experience that the integration of provider clinical expertise and adherence to Evidence-Based Clinical Practice Guidelines (EBPGs) coupled with a strong relationship between the member and provider, results in improved health care outcomes and positively impacts members' quality of life. The provider can be the single most influential person to impact a member's change in behavior. As such, the provider is a key element to our chronic care programs. We have implemented physician pay-for-performance programs that directly link the providers' adherence to Evidence-Based Clinical Practice Guidelines to reimbursement as a tool to increase physician compliance.

MCP understands that provider education is critical to implementing EBCPGs. MCP provides a range of methods to educate providers regarding EBPGs; these include, but are not limited to: 1) instructor-lead training; 2) MCP's provider web portal, 3) MCP's provider manual; 4) online provider newsletters; and 5) by provider request. To monitor provider compliance with EBCPGs, MCP conducts Ambulatory Medical Record Reviews AMRRs. MCP has established a minimum performance standard for providers' compliance with EBCPGs and requires submission of Corrective Action Plans (CAPs) for providers who fail to meet these standards. Through the CAP, the provider is then required to outline actions to be taken for improved compliance with EBCPGs.

The CM is integral to implementation of MCP's chronic care programs. The CM's role is critical because: 1) works closely with the member and the member's family/caregiver to assist them in navigating through the fragmented and complex health care delivery system; 2) authorizes all services specified in the member's care plan; 3) prevents delays in service implementation; 4) assist the member in scheduling quarterly PCP visits; 5) provides accurate and updated information related to the member's current status and services to the PCP; 6) avoids duplication of services; 7) facilitates safe care transitions from, and between, care settings; 8) conducts ongoing assessments of service needs; 9) coordinates with Schaller's disease managers to support planned interventions; 10) MCP employs motivational interviewing skills to empower the member in taking an active role in the self-management of their disease; and 11) acts as the member's advocate within MCP, with the PCP, and engage/link the member with community resources/stakeholders. Our CMs identify when a member is having difficulty adhering to the member-centered care plan. Our CMs are skilled at identifying adherence issues and changes in a member's level of engagement so that they can intervene quickly and assist the member in getting back on track or employ alternative approaches to actively involve the member

MCP has developed and is in the process of implementing our first disease specific PCMH. Working with a key provider group we will offer and enroll MCP diabetic members in a patient-centered medical home model to provide comprehensive, high quality, and individualized care. This will be a voluntary program for diabetic members. The design of this holistic PCP-led PCMH is to meet the needs of our diabetic members using a combination of community navigators, self-management tools/education, community partnerships, and MCP CMs. The purpose of this disease specific PCMH is to: 1) improve health outcomes of our diabetic members; 2) reduce avoidable utilization of high cost services (hospital admission, ED visits); 3) use telehealth monitoring for those members identified as highest risk; 4) to align incentives between MCP and providers by evaluating a new payment model that include fee-for-service, P4P and payments for medical support services. MCP is excited about this opportunity because it provides a unique and comprehensive method to deliver health care services to members with complex chronic diseases. The CMO is actively working with the QM/UM committee, other internal departments, and this provider to finalize this model for introduction this year.

28.



## Question 28 – Medical Management

Mercy Care Plan (MCP) uses nationally recognized clinical criteria to guide our medical decision-making. We design, manage and administer our process to adopt and disseminate clinical criteria to provide an environment for consistent, collaborative, culturally competent, and optimal utilization of care that is responsive to our members' needs and providers' expectations. The Southwest Catholic Health Network (SCHN) Board of Directors (hereinafter referred to as the Board) has ultimate authority and responsibility for our utilization management (UM) program. The Board has delegated responsibility for our UM program to the chief executive officer (CEO). The CEO has delegated day-to-day management responsibility and authority to the chief medical officer (CMO). The CMO has responsibility for the management and supervision of our medical directors; including their use and application of clinical criteria. The CMO delegates to the vice president of utilization management (medical management coordinator) responsibility for applying, monitoring, reporting, and supervising prior authorization and concurrent/retrospective review activities.

MCP has written Policies and Procedures (P&Ps) that govern the adoption and application of clinical criteria to support individualized clinical decision making. Our P&Ps include detailed standards, clinical criteria protocols, review criteria, turnaround timeframes and other information relevant to making consistent, and responsive decisions including, but not limited to: 1) level of care, 2) place of service, 3) scope of service, and 4) duration of service. MCP's P&Ps require that: 1) only a medical director with appropriate clinical expertise in treating the member's condition or disease can deny a request for services; reduce the amount, duration, or scope of care; or excluded or limited services; 2) individuals who conduct utilization management activities are not compensated nor is our compensation structured or designed to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services; 3) prior authorization is unnecessary for emergency medical services. Our CMO is responsible for the development, completeness, relevance and accuracy of our clinical criteria P&P. When applying clinical criteria, we consider the member, the member's support system, the member's diagnosis, the member's disease stage, co-occurring medical/behavioral health conditions and member's individual care plan. It is our standard operating procedure to annually review our clinical criteria P&P and clinical criteria. The results of this review are presented to our QM/UM Committee for consideration and action - accept, modify or reject the clinical criteria. Our QM/UM Committee annually reviews, analyzes and approves our clinical criteria. Chaired by the CMO or designee, the QM/UM Committee meets monthly. Membership in the QM/UM Committee includes MCP medical directors; vice president of utilization management (medical management coordinator); chief operating officer or designee; vice president of quality management; Case Management Administrator/Manager; Director of Integrated Case Management; Director of Provider Services; Vice President of Member Services; local community-based and network (participating) PCPs; specialists; behavioral health providers; and other personnel as needed. Prior to each meeting, participants and members of the QM/UM committee must execute a confidentiality and conflict interest agreement. The QM/UM Committee determines if actions are needed regarding: a) the process to design, develop or adopt clinical criteria; b) training of providers on applicable clinical criteria; b) MCP staff training how to administer or apply the clinical criteria; and/or c) the information available to providers or members regarding clinical criteria. The annual review process consists of an evaluation of: i) existing criteria, ii) new medical technologies; iii) changes in covered services, practice patterns, or members' medical needs, and iv) determination of any recommendations or changes. Through our QM/UM Committee, we receive recommendations from providers in the adoption, review, and dissemination of clinical criteria. The use of this multidisciplinary process allows for a wide range of local medical knowledge, including specific local community-base experience related to providing care to patients with similar characteristic as our members, to be considered and applied during the design, development, adoption, and re-evaluation of our clinical criteria. It is our experience that this process lays the foundation for continual improvement, understanding, and acceptance of our clinical criteria. The CMO presents our clinical criteria to the Board's Quality Subcommittee (Quality Subcommittee) for approval. Our CMO, QM/UM Committee and Quality Subcommittee manages and directs this process so that our clinical criteria encompasses local care standards and consistently results in appropriate decision-making, course-of-action and/or interventions necessary to improve: 1) health outcomes, and 2) quality of clinical care and or 3) maintain compliance with prudent practice measures. It is our experience that a multidisciplinary development process that includes local providers will encourage acceptance of clinical criteria by other community providers. We notify AHCCCS of any changes to clinical criteria P&P in accordance with AHCCCS' policies, standards, or regulations.

MCP has a long and proven history in the development, approval and dissemination of clinical criteria for decision making. We base our process on the following standards: a) Clinical criteria are adopted only from nationally recognized professional organizations or through the involvement of clinical providers from the appropriate specialties when clinical criteria are internally developed; b) Clinical criteria must be relevant to the disease-state and challenges of our members

and c) Clinical criteria are adopted in consultation with local community-based physicians with experience treating patients with those illnesses or diseases. One of our goals is to reduce/eliminate health disparities and improve health outcomes of our members. Therefore, we consider the appropriate and responsive design, dissemination, and deployment of clinical criteria as a management, administrative and training priority

Our protocols for developing, reviewing, adopting and annually evaluating clinical criteria is based on a formal and systematic review of nationally recognized standards, and takes into consideration local/regional practice patterns. For instance, we selected Milliman Care Guidelines™ as one of our sources of clinical criteria because it spans a wide continuum of care including ambulatory care, inpatient and surgical care, general recovery guidelines, recovery facility care, home care, and chronic care. Our process includes using several evidence-based medicine sources to access and validate our clinical criteria. Examples of sources that may be surveyed or consulted during this process include, but are not limited to, 1) U.S. Food and Drug Administration; 2) ClinicalTrials.gov; 3) National Guideline Clearinghouse; 4) Centers for Medicare & Medicaid Services; 5) Centers for Disease Control and Prevention; 6) National Asthma Education Prevention Program Guidelines; 7) National Heart Lung and Blood Institute; 8) American Heart Association; 9) National Institutes of Health; 10) American Diabetes Association/Diabetes Care; 11) American Psychiatric Association; 12) IAHPC; and 13) IDSA. MCP clinical criteria includes: a) AHCCCS medical policy manual (AMPM), b) MCP's utilization management policies/procedures, c) Milliman Care Guidelines™, CMS, Aetna Clinical Policy Bulletins, LOCUS/CALOCUS guidelines and American Society of Addiction Medicine (ASAM ), and d) Clinical Pharmacology.

Personnel who will administer, manage, communicate or process clinical criteria must attend a mandatory 4 week skills based training program that includes training on MCP clinical criteria: a) AMPM, b) MCP's utilization management policies/procedures, c) Milliman Care Guidelines™, Aetna Clinical Policy Bulletins, LOCUS/CALOCUS guidelines and American Society of Addiction Medicine (ASAM ), d) the ALTCS program (including population, confidentiality, TPL, dual eligibles, geriatric and disability issues, grievance, confidentiality, MCP P&P, ALTCS program, cultural competency, member rights and responsibilities, health literacy, role of clinical criteria in utilization/quality management and covered services), and e) our Medical Management Plan. It is required that personnel from utilization management (e.g., prior authorization, utilization review and retrospective review), and medical directors attend and successfully complete the initial and annual training program. These personnel must pass mandatory annual refresher training. This is a rigorous training program that includes routine monitoring of staff using clinical criteria to monitor consistency of decisions. In addition, personnel from provider services, member services, claims administration, and grievance and appeals receive initial and on-going training regarding clinical criteria.

For consistent application of clinical criteria by MCP utilization management personnel our P&Ps are to hire utilization management personnel who render decisions applying clinical criteria for skilled and non-skilled services must have: 1) an appropriate Arizona license as appropriate or required and in good standing with applicable board; 2) an adequate experience may substitute for licensure for certain CMs with a minimum of five (5) years of continuous experience in Long Term Care to be a Long Term Care CM; 3) a minimum of three (3) of experience and an appropriate bachelors or masters degree in a related field to be a Long Term Care CM.

MCP's UM Department is responsible for compiling data, conducting and documenting reviews and inter-rater reliability (IRR) assessments, and reporting the results to our CMO. The CMO prepares a report for the QM/UM committee on the total number of utilization management personnel evaluated, the range of scores and the number of corrective action plans developed. The CMO reports to the Board in the annual Utilization Management Evaluation report. MCP uses IRR assessments to determine the consistent application of review criteria and confirm that consistent decisions are made by utilization management personnel, including medical directors, when applying Milliman Care Guidelines™, CMS guidelines and Aetna Clinical Policy Bulletins to decisions. MCP has written P&Ps that govern the IRR process. The CMO is responsible for the integrity of the IRR process. The utilization management assessment incorporates use of the correct guideline and process for clinical decision-making. We test IRR on a regular basis, but not less than annually to maintain uniform application of the clinical care criteria. In 2010, all utilization management employees (40 staff) took the IRR assessment averaging an overall score of 94.5 percent; the score is well above the 85 percent P&P benchmark. Corrective education plans are instituted in the event that individual results fall below benchmarks. In addition to IRR, MCP uses other monitoring methods to identify areas of improvement for our PA processes. These include monthly quality review audits to assess staff adherence to authorization policies and timeliness standards. Individuals whose audits fall below 90 percent receive re-training and may be subject to disciplinary action.

Planning for successful design, development, adoption, and dissemination frames our overall process and continues throughout the cycles of review, revision and updating. The effective and efficient delivery of medically necessary care to



our elderly and disabled ALTCS members is dependent in many ways on our specific, comprehensive, and flexible clinical criteria to guide everyday clinical practice and decision making.

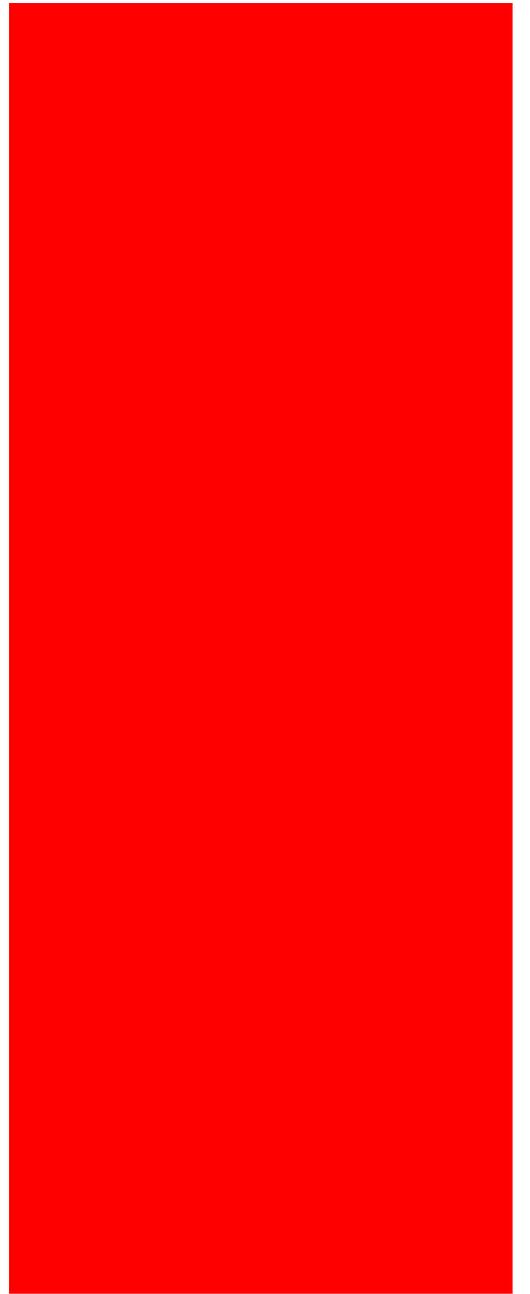
MCP uses multiple resources and media for dissemination of clinical criteria to our providers and members. It is our standard operating procedure to maintain a complete inventory of all clinical criteria on our web site. We also use the following communication, media and resources for disseminating clinical criteria: a) provider manual; b) site visits and individual provider training; c) provider group meetings; d) blast faxes; and e) member and provider profiling. A provider may obtain a current and valid copy of our clinical criteria from our web site or by contacting the Provider Services Representative office. We also actively disseminate clinical criteria through our prior authorization, concurrent review, quality management, and case/disease managers when they interact with participating or non-participating providers. Clinical criteria are readily available to our members, and potential members through our web site, member handbook, member newsletters or by contacting member services. Milliman Care Guidelines™ are available to providers and members upon request. MCP makes all clinical criteria utilized for clinical decision-making from public sources available to providers as described in the table below. There is never a cost charged to either providers or members when clinical criteria are requested.

Member Information	Provider Information
Member website	Provider web portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Team	Provider Services Representative
Care Plan	Care Plan
Member Call Center (Toll free call)	Provider Service Center
UM/PA – Notice of Action Letter	UM/PA – Service Approvals/Denials

MCP uses nationally recognized, evidence-based review criteria to improve the consistency of decisions made by our clinical utilization management staff. These clinical criteria represent best practices and reflect national standards. These clinical criteria also support medical necessity determinations in conjunction with our utilization management processes. MCP uses the following guidelines for medical necessity reviews. These are to be consulted in the order listed if the specific request is not addressed by the previous set of criteria:

- For physical health, Milliman Care Guidelines™ are used as the primary decision support for most diagnoses and conditions
- For BH, LOCUS and CALOCUS are used as the primary decision support for most diagnoses and conditions
- For addiction, American Society of Addiction Medicine (ASAM ) are used as the primary decision support for most addiction diagnosis and conditions
- Aetna Clinical Policy Bulletins (CPBs) are used to supplement Milliman Care Guidelines™, LOCUS, CALOCUS or AHCCCS AMPM in order to effectuate the clinical decision to determine appropriate medical necessity

29.



## Question 29 – Quality Management

Mercy Care Plan (MCP) incorporates performance improvement projects (PIPs) into its quality management and performance improvement program (QM/PI) in order to improve: 1) quality management, utilization management and medical management activities; 2) service delivery protocols and network adequacy; 3) administrative or non-clinical activities such as grievance/appeals, member services and training (internal staff and providers); and 4) cooperation and communication within and between MCP's units, providers and member to enhance the quality of care and services we provide to our members.

MCP uses best practice methodologies to continuously examine data and processes, implement interventions, and re-examine our clinical, management and operational processes to identify QM/PI opportunities. The purposes of our QM/PI activities are to promote: a) positive health outcomes for our members; b) the quality of member-directed covered health care services spanning all delivery sites, and c) appropriate, cost effective use administration of clinical and non-clinical programs, services, and care. MCP's chief medical officer (CMO), with the support of the Vice President of Quality Management (Quality Management Coordinator) and the Performance/Quality Improvement Coordinator, manages and directs the selection, design, implementation, and evaluation of each PIP. This workgroup collaborates with executive and management staff to make certain that each PIP complies with AHCCCS' requirements, integrates results from AHCCCS' Operational and Financial Reviews, follows federal protocols, and adheres to CMS and NCQA standards. Under the supervision of the CMO, the Quality Management Department, led by the Quality Management Coordinator is responsible for implementing, managing, tracking, and reporting PIP activities.

MCP has an outstanding history of establishing and maintaining high quality standards and excellent performance, including sustained continuous improvement in our clinical and operational programs that result in improvements in health outcomes for, and satisfaction of our providers and members. The foundation of our QM/PI program is our Quality Management/Performance Improvement Plan (QM/PI Plan) which provides the administrative and functional framework for our quality and performance improvement activities for 1) identifying and selecting Performance Improvement Project (PIP) topics; 2) inter-department communication, cooperation, and coordination; 3) evaluating effectiveness of our interventions; and 4) guiding our processes for assessing clinical and non-clinical processes. Through experience, we have learned that internal communication and communication with our providers and members is critical for a successful QM/PI program.

*In the 2010 Operational, Financial Review (OFR), for the first time in AHCCCS history, MCP achieved full compliance of all QM/PI standards.*

### Identifying and Selecting Performance Improvement Project (PIP) Topics

MCP PIP topics are selected either by AHCCCS or identified through data analysis regarding our elderly and physical disabled member's needs, care, and services. MCP actively participates in, and contributes to AHCCCS statewide PIPs and may implement specific PIPs to focus on identified clinical and non-clinical areas. Generally we identify and select clinical and non-clinical topics, through continuous data collection and analysis, that will affect a significant portion of our members; include high-volume or high-risk conditions and, lead to improvements in member's health, functional status or satisfaction as a result of the PIP process.

The Quality Improvement Committee (QIC), chaired by the CMO or designee, includes the following multi-departmental personnel: 1) COO; 2) Vice President (VP) of Quality Management (Quality Management Coordinator); 3) Case Management Administrator/Manager; 4) Director of Integrated Case Management (physical and behavioral health); 5) VP of Member Services; 6) Director of Provider Services; 7) Dispute and Appeal Manager; 8) VP of Utilization Management (UM coordinator); 9) Director of Prevention and Wellness (EPSDT Coordinator); and 10) VP of Health Plan Operations. This committee, that meets weekly, selects each PIP topic based on: a) objective performance indicators including AHCCCS performance measures, b) quality of care concerns including trends from peer review; c) member's demographic characteristics and health risks; d) prevalence of the chosen topic or condition within our membership; e) member and care giver input; f) provider input; g) utilization management activities; and h) trends identified through network/performance monitoring, results of credentialing/re-credentialing, utilization management outcomes and actuarial analysis (member/provider profiling). An overriding selection factor is our ability to achieve significant improvement sustainable over time in clinical care and non-clinical care areas through the selected topic. After selecting a PIP topic, the QIC prepares a PIP proposal that is reviewed and approved by the (QM/UM) Committee, which includes local community-based network providers and our governing body, the Southwest Catholic Health Network (SCHN) Board of Director's Quality Subcommittee (Quality Subcommittee).

## **Enhancing and Implementing Multi-Departmental Interventions**

Within MCP, multiple operating and care delivery/management departments work in close cooperation and collaboration to develop, investigate, implement, and share information to achieve our goal of quality and performance improvement in the care and services we provide to our members. The foundation of MCP's process is to enhance and implement our QM/PI opportunities and interventions by establishing, reinforcing, and facilitating a cross-functional approach through leadership from our senior management team, consistent internal communication about QM/PI activities through the committee structure, and ongoing training. MCP's approach to developing PIP interventions occurs through the QIC whose membership includes representatives from our managerial, operational, information technology, quality, and utilization personnel. The responsibilities of the QIC are to: 1) perform root cause analysis and propose evidence-based interventions; 2) cross-functionally discuss the PIP topic, purpose, objectives and timeframes; and 3) determine that the intended PIP outcome is reasonably attributed to the planned interventions.

Our process is iterative, multi-departmental, and multi-disciplinary; the exchange of information and ideas during this process is instrumental to the effectiveness of our interventions. This enables every department to contribute to the optimal design of each intervention. Our executive leadership and management team responsible for Medical Management, Member Services, Behavioral Health, Case Management, Network Development and Contracting, and Provider Services are responsible for disseminating, orientating, and training personnel about the value and importance of our QM/PI programs, activities and outcomes. As part of the required annual performance assessment, we evaluate and document strategies, activities, communication, and feedback that each segment of the management team contributed to MCP's QM/PI program. QM/PI program communication includes our network providers and members; we encourage, value, and support input from our providers and members to improve the performance of our QM/PI program.

## **Evaluating the Effectiveness of Interventions**

MCP performs systematic, consistent, ongoing collection and analysis of, accurate, valid, and reliable data to evaluate the effectiveness of interventions. MCP's state-of-the-art information technology system provides the data collection, storage, integration, validation and retrieval resources, and support for identifying, selecting, tracking, and analyzing data/information to facilitate our PIP development, study and evaluation efforts. In utilizing the Plan-Do-Study-Act (PDSA) model, MCP establishes baseline measures using performance measures, study indicators, and targeted benchmarks. To assess the overall effectiveness of interventions, we compare the results of re-measurement periods to the initial baseline measurement results and our targeted benchmarks. We then determine 1) if there is quantitative, measurable and sustained improvement in processes or outcomes of care according to the predetermined PIP study indicators, 2) if the improvement in performance is a result of the planned interventions or to some unrelated occurrence, and 3) if there is any statistical evidence that the improvement reflects true improvement.

When MCP presents the statistical results to the Board's Quality Subcommittee, to AHCCCS, or to our providers it is our standard operating procedure to fully disclose the study's purpose, methodology, and outcomes, including the statistical significance of the results. To demonstrate quantifiable evidence of improved quality of care or services, we measure improvement according to benchmarks established by AHCCCS or the QIC (for internally selected PIPs).

MCP utilizes the PDSA model to document the results of our QM/PI program. The QM Department conducts continuous data analysis to determine if current performance represents a statistically significant improvement, and if the improvement can be reasonably associated to the interventions. Each of our quality improvement studies or activities has one or more quality indicators we use to track, analyze, and report improvement and performance during the life cycle of the activity. We determine the effectiveness of interventions based on the statistical significance of improvements to objective, clearly defined and relevant indicators. If more than one (1) qualified and trained staff person is used to gather and record data, we use inter-rater reliability approaches to monitor consistency of data management.

MCP determines the effectiveness of interventions by measuring statistically significant changes in performance according to predefined quality indicators. If our continuous measurement and data analysis indicates that our interventions were unsuccessful, we report our findings to the QIC, to AHCCCS and to providers. The QIC reviews this information and takes action based upon the results of the interventions, and determines to continue existing interventions, modify any interventions, or discontinue ineffective interventions. The QIC reports its findings to the QM/UM Committee and the Board's Quality Subcommittee. The Board's Quality Subcommittee provides direction on additional enhancements to improve the effectiveness of interventions. This cycle continues until real and sustained improvement is achieved. If our continuous measurement and data analysis indicates that our interventions were successful, we incorporate these interventions into our ongoing quality management processes.

MCP uses the results of its monitoring and evaluation of overall performance to assess our QM/PI program. As part of our assessment process, we distribute results of the PIP and QM/PI program outcomes to internal staff and our network serving each Geographic Service Area (GSA). Our ongoing monitoring and evaluation process includes an annual assessment of the efficacy of each member and provider intervention(s). We use these results to develop our work plan for the subsequent fiscal year, which forms the basis for the QM/PI program activities for the next year. This allows us to base improvements to our QM/PI structure on the effectiveness and success of implemented, evidence-based interventions.

MCP ALTCS participated in the statewide AHCCCS’ Documentation of Advance Directives PIP. The purpose of this PIP is to measure the use of advance directives by ALTCS members, as documented in their medical records, and to educate members or their authorized representatives about advance directives. AHCCCS furnished a statewide report on the percentage of members having documented evidence of an advanced directive in their medical records. The report indicated that 27.7% of MCP ALTCS members had evidence of an advanced directive. The first re-measurement period indicated MCP realized a statistically significant improvement. The overall rate increased to 49.3%.

**MCP’s Documentation of Advance Directives:  
First Re-measurement compared with Baseline Measurement**

Contractor	n	Number of Members with Advance Directive	Percent of Members with Advance Directive	Relative Change from Previous Year	Statistical Significance
Mercy Care LTC	361	178	49.3%	78.2%	p<.001
	365	101	27.7%		

Notes:

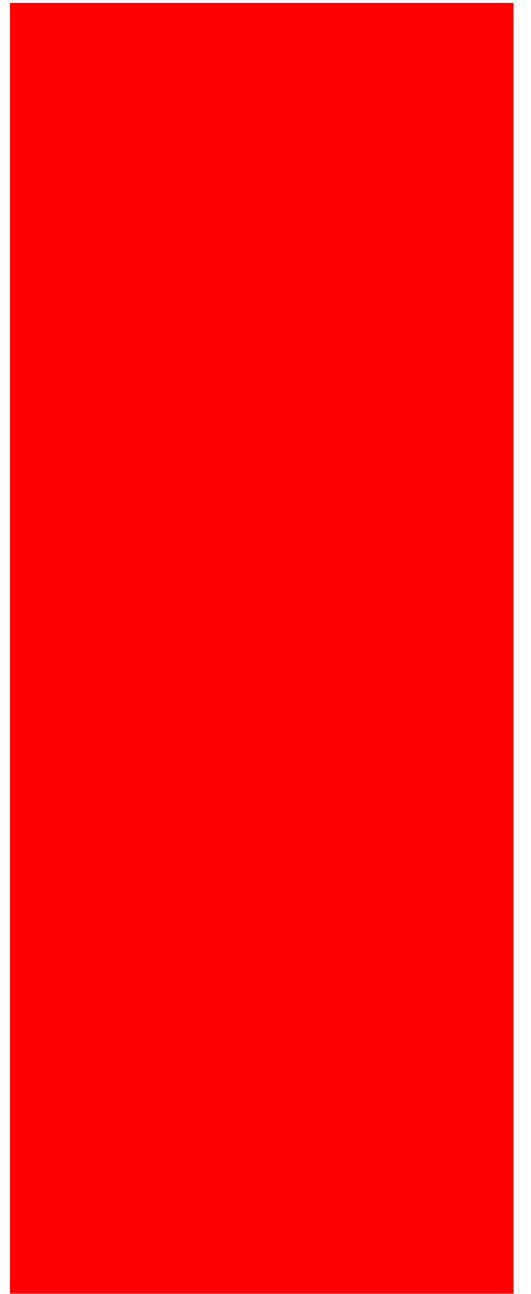
Shaded rows include results of baseline measurement period, Oct. 1, 2006, through Sept. 30, 2007.

Changes from the baseline measurement are considered statistically significant when p ≤ .05; statistically significant values are shown in bold.

The statistically significant improvement noted in the data above was the direct result of MCP’s ALTCS management staff implementing the following member and provider interventions:

- Used a one-page (two-sided) Advanced directive form developed by Health Care Decisions in order to simplify the process and enable members to better understand Advanced Directives;
- Trained all ALTCS Case Managers (CMs) on the reasons for, and completion of advanced directives. A corresponding Advanced Directive Policy and Procedure (P&P) was created for the staff’s reference;
- CaseTrakker™ (the internal MCP medical management tracking tool) was updated to include the event “advanced directive” as a means to track the progress of having an advanced directive for all members;
- Starting in October, 2008 the ALTCS CMs discussed advanced directives with each member. CMs had the member complete two originals: one for the member record, the other to be sent to the member’s PCP;
- ALTCS supervisors and CMs were required to run reports in the CaseTrakker™ system to track progress in obtaining advanced directives for the members.
- In 2010 MCP’s Long Term Care in conjunction with Provider Services developed a Pay-for-Performance program for contracted NFs and ALFs with the goal of improving the percentage of diabetic members receiving recommended screenings, and the goal of increasing the number of members with completed Advanced Directives. The program began on May 1<sup>st</sup> 2010 and ended on August 30<sup>th</sup> 2010.
- Providers were eligible for compensation if at least 85 percent of the members identified showed evidence of completion for any of the indicators. The amount of the incentive was based upon the number of members and the length of time the members were in the facility during the measurement period. Facilities worked cooperatively with the MCP’s CMs to document progress with completion of the indicators. Over \$500,000 was disbursed to providers who exceeded the minimum performance thresholds on one or more measures. When compared to historic performance rates, several of the measures improved following the program.

30.



## Question 30 – Quality Management

Mercy Care Plan (MCP) embraces a continuous quality improvement model that includes peer review to evaluate the medical necessity, quality or utilization of care/service provided by a provider. The purpose of our peer review process is to improve the quality of medical care provided to our members by both participating network and non-participating providers. Through this process, we review and address specific care, service, or utilization issues arising from the activities of providers or other providers in order to improve the quality and appropriate utilization of health care services to members. Our Quality Management Department, under the leadership of the Chief Medical Officer (CMO) facilitates the peer review process and incorporates the results into ongoing quality management processes to target improvements and make system enhancements.

MCP's peer review process is designed to: 1) identify quality and utilization issues that require review; 2) provide review of identified issues with contracted providers pursuant to program and contractual requirements; and 3) use the expertise and knowledge of contracted community providers in improving the quality and appropriate utilization of care and services delivered to MCP members. Peer review is conducted internally by MCP and is a required component of our Quality Management Performance Improvement (QM/PI) program. The process is conducted under applicable state and federal laws, and is protected by the immunity and confidentiality provisions of those laws. Our peer review reports, meetings, minutes, documents, recommendations, and participants remain confidential except for purposes of implementing recommendations made by the peer review committee. Providers are notified and educated about MCP'S peer review process in the provider manual.

### Peer Review Structure

MCP's Chief Medical Officer (CMO), with the support of the Vice President of Quality Management (Quality Management Coordinator) is responsible for developing and implementing our quality management/performance improvement plan. The MCP QM/UM Committee, is chaired by the CMO, and the membership includes the Chief Executive Officer (CEO), Chief Operating Officer (COO), Quality Management Coordinator, Vice President of Utilization Management, Directors and Managers from Medical Management, Performance/Quality Improvement Coordinator, and Long Term Care Director; MCP Medical Directors including the Behavioral Health (BH) Medical Director; Dental Medical Director; and representation of contracted providers from local communities in which MCP has enrolled members. Our CMO also chairs the Peer Review Committee, which meets monthly in executive session of the QM/UM Committee. This committee is comprised of MCP Medical Directors and contracted community providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the provider under review. Members of this committee execute a confidentiality agreement and conflict of interest statement prior to participating at each meeting. Committee members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. MCP's CMO may invite providers with a special scope of practice or utilize an outside peer review agency, when necessary.

### Peer Review Decision-Making

MCP's independent Quality Management (QM) Department is responsible for the initial referral, evaluation, and presentation of quality and utilization concerns to the CMO. Cases referred for peer review include those cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or service, by a participating or non-participating provider. The CMO recommends cases to be presented to the Peer Review Committee.

After reviewing all information available through MCP's quality management processes the physicians of the Peer Review Committee are charged with advising the CMO, and developing recommendations for action. Based upon the presented information, the Peer Review Committee may:

- Request additional information
- Assign or adjust the severity level
- Request outside peer review consultation and report prior to rendering a decision, if such a consultation was not already ordered by the CMO
- Recommend that the CMO take actions, which may include, but are not limited to the following:
  - *Peer contact:* The Committee may recommend that the MCP Medical Director or CMO or a designated medical director contact the provider to obtain additional information or discuss the committee's action.
  - *Education:* The Committee may recommend that MCP send information or educational material to the provider or that the provider seek additional training.

- *Committee appearance:* The Committee may recommend that the provider attend a committee meeting to discuss the issue with committee members.
- *Credentials action:* The Committee may recommend that MCP reduce, restrict, suspend, or terminate the provider’s MCP credentials necessary to treat members as a participating provider.
- *Corrective Action:* The Committee may recommend that MCP limit the provider’s new member enrollment, issue sanctions, or require other corrective action.

After review of the Peer Review Committee deliberations and recommendations, the CMO makes a final decision upon the referred case. Based on findings of the review or investigation of a quality of care concern, MCP may take one or more of the following actions if the peer review committee determined care was not provided according to community standards:

- Report its findings to AHCCCS and Child or Adult Protective Services, or the appropriate state agency for further investigation or action of alleged or potential abuse.
- Report to Arizona Department of Health Services, Division of Healthcare Licensure (ADHS/DHL), all substantiated quality of care issues concerning agencies and facilities licensed by ADHS/DHL. The initial report may be made verbally, but must be followed by a written report.
- Report to AHCCCS and any other appropriate regulatory board or agency (e.g. Arizona Medical Board, Arizona Board of Osteopathic Examiners, Arizona Board of Nursing, Healthcare Integrity and Protection Databank (HIPDD), ADHS (Division of Licensure Services) if the CMO suspends or terminates a provider’s affiliation with MCP due to quality of care issues.
- The CMO may act independently when issues are identified that pose an imminent threat to a member’s health and/or safety. Following such notification, the CMO in turn notifies the Peer Review Committee of the action.

The CMO notifies the Southwest Catholic Health Network (SCHN) Board of Director’s Quality Subcommittee (Quality Subcommittee) of the decision that he/she rendered for the referred case. MCP notifies the affected provider of the proposed action by registered mail within seven days of the CMO’s decision, including their rights for filing a grievance regarding the results or findings of the peer review process.

### **Incorporating Peer Review into Quality Management Processes**

MCP considers peer review to be critical for evaluating and addressing medical care, service, and utilization issues arising from activities of an individual provider, group of providers, or facilities. As an integral component of MCP’s Quality Management program, we use peer review findings to analyze and address clinical processes, including:

- Quality Improvement. Trended peer review results may lead to a planned intervention, such as the development of a PIP.
- Provider Re-credentialing. The results of peer review are placed in the providers’ file for review during re-credentialing.
- System Enhancements. MCP tracks and trends both peer review referrals and findings in order to identify systemic issues that may affect the quality of care provided to our members. We review this information and make recommendations for system enhancements and evidence-based interventions.

MCP reviews trended information from peer review and other performance measures on a monthly basis in order to target improvement efforts. The QIC, the Service Improvement Committee (SIC), and other MCP committees review this data and takes action based upon the results of the interventions and determine to keep existing interventions, modify any interventions, or discontinue ineffective interventions. The QIC reports its findings to the QM/UM Committee and the Quality Subcommittee, which provides direction on additional enhancements to improve the effectiveness of interventions.

MCP’s process for incorporating peer review data into the QM/UM structure results in improved member care. For example, through peer review data, we identified the need to improve oversight of nursing facilities. Our QIC reviewed this data and took action to implement system-level interventions. MCP then took a lead role in collaborating with the Arizona Department of Health Services (ADHS), Licensure Division, and two other contractors in Maricopa County to modify and streamline the oversight and monitoring of contracted nursing facilities. This collaborative model has been well received at national meetings and many of the lessons learned have served to improve the protocols and processes used to monitor nursing facilities in Arizona. This project serves as one of the building blocks for the Advancing

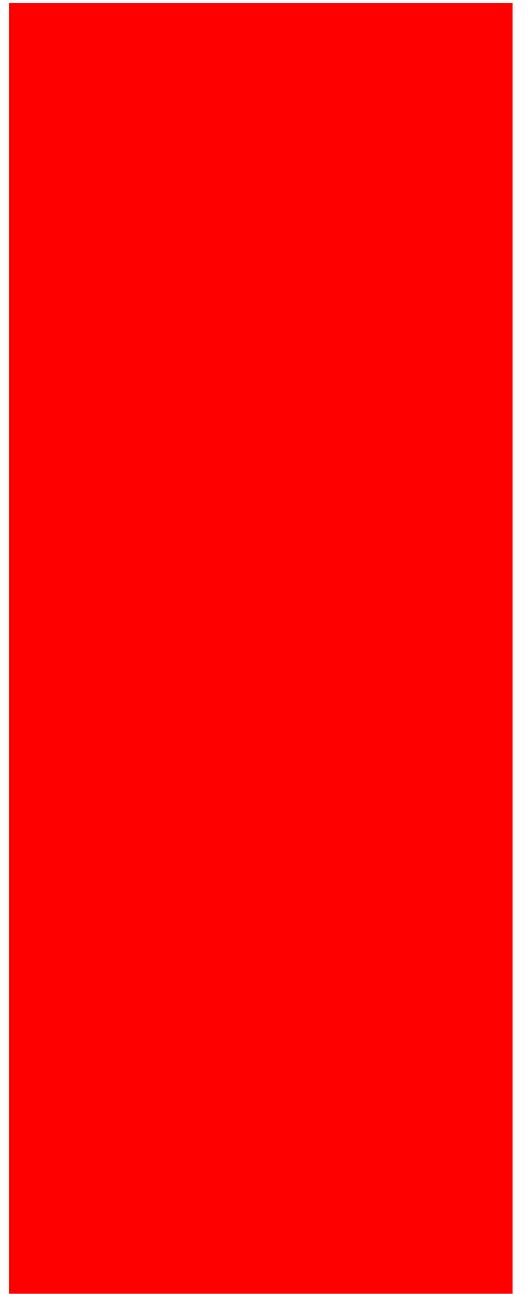


Excellence in America's Nursing Homes Campaign, which is an ongoing, coalition-based campaign concerned with how we care for the elderly, chronically ill and disabled, as well as those recuperating in a nursing home environment.

As another example, MCP used the trended data from peer review to improve the quality of care to members requiring durable medical equipment (DME). We tracked and trended complaints and quality of care issues from a specific DME provider and presented findings from the peer review process. As a result, MCP terminated the DME provider and expanded the DME provider network to enhance member choice.

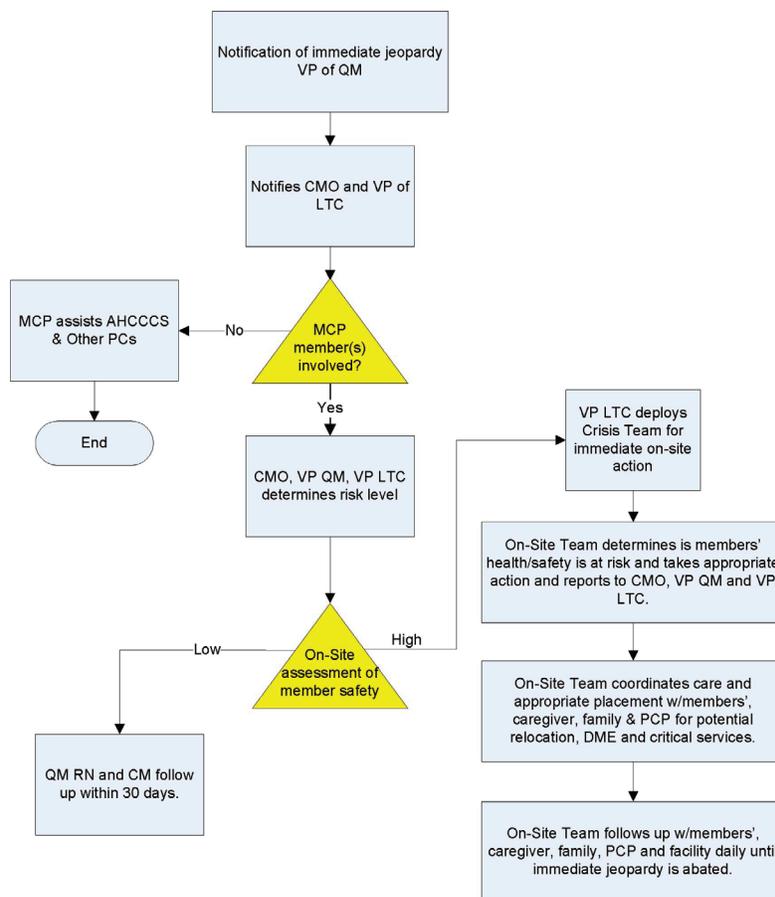
The structure of our peer review committee and the decision making process we use contributes to our outstanding quality management process. MCP's executive leadership and management team dedicates the resources to the peer review and quality management process to provide the most responsive and responsible program and network. MCP's highly successful program, process, management and administrative program/process make MCP the health plan of choice for both members and providers.

31-A



### Question 31 – Quality Management (Case Scenario A)

Mercy Care Plan (MCP) is committed to making sure our members have access to the highest quality of care. Relative to the severity of the complaint, we timely, appropriately, and thoroughly investigate all quality of care concerns. In Immediate Jeopardy (IJ) situations, we have selected the Case Management Administrator/Manager and the Vice President of Quality Management (aka: Quality Management Coordinator) to be available 24 hours-a-day, seven-days-a-week to collaborate with AHCCCS and/or ADHS to resolve IJ situations and AHCCCS has been notified of our selection. The Southwest Catholic Health Network (SCHN) Board of Director (the Board) has ultimate authority and responsibility for our quality management (QM) program. The Board has delegated responsibility for our QM program to the Chief Executive Officer (CEO). The CEO has delegated day-to-day management responsibility authority to the CMO. The chief medical officer (CMO), with the chief operating officer (COO) has responsibility and authority over our IJ standard operating procedures (SOP). MCP’s IJ written Policies and Procedures (P&Ps) document our standard operating procedures (SOPs) for responding and managing, such incidents and providing protocols to protect the health and safety of our members. Our P&Ps require involvement of personnel from multiple MCP departments to work in collaboration with AHCCCS, ADHS, and other involved program contractors. To protect the health and safety of our members it is our SOP to be at the facility within one (1) hour of notification for each IJ incident. Our IJ Crisis Team (“the Crisis Team”) is deployed to respond to and manage the IJ situation. The CMO has designated the Case Management Administrator/Manager as the lead of our Crisis Team. The Crisis Team includes the Vice President of Quality Management, Case Management Supervisor, Long Term Care Case Managers (CMs); and Quality Management RN(s), Vice President of Member Services, Vice President of Utilization Management, Director of Provider Services, Director of Marketing, and leaders from other departments as needed. The Crisis Team is empowered by the CMO to make immediate decisions to protect the health and/or safety of our members and abate any concerns. The chart below outlines our process for responding to IJ situations.



Following the process described above, MCP responds to Scenario “A” as:

MCP’s vice president of quality management receives notification of the IJ and serves as the single point of contact available to work with AHCCCS. The vice president of quality management immediately (within 5-10 minutes after initial notification –MAIN) contacts (depending on the day/time and circumstances via in person, email, text message, and telephone call) the CMO or designate medical director, and the Case Management Administrator/Manager; to review the

IJ. Based on the information available, the CMO or designated medical director, in consultation with the VP of Quality Management and Case Management Administrator/Manager, confirms that this is a high risk situation (within 7-12 MAIN). Based on this decision, the Case Management Administrator/Manager immediately mobilizes (depending on the day/time and circumstances via in person, email, text message, and telephone call) the Crisis Team. At the same time as the Crisis Team is mobilized, the Case Management Administrator/Manager will notify leadership of critical MCP departments (Prior Authorization/Concurrent Review and Provider Services) that the facility (hereinafter referred to as ALF) is unavailable for new admissions (both steps will occur within 9-15 MAIN).

The Case Management Administrator/Manager, in consultation with the vice president of quality management, will select the On-Site Team lead (occurs within 10-16 MAIN). The Crisis Team lead utilizes the placement roster to identify the MCP members residing at the facility. The On-Site Team lead will immediately research each member using our CaseTrakker™ system to determine the members' medical history and care plan and contacts the ALF's manager to obtain the current health status of each member (occurs within 11-20 MAIN). The On-Site Team lead will be a Long Term Care Manager who is the most familiar with the facility (e.g., the CM assigned to the facility reports in the Long Term Care Manager's span of control). The Case Management Administrator/Manager, the VP of QM, and the On-Site Team lead will select the On-Site Team (occurs within 11-17 MAIN). Personnel from long-term care CM and QM are on-call for crisis situations and as part of their on-call status and, (they are required to identify a substitute if they are unavailable) must be available within 10 minutes to respond to IJ. The On-Site Team lead selects the On-Site Team. The On-Site Team, for this scenario, includes a case management supervisor, two (2) CMs and one (1) QM RN (occurs within 13-18 minutes MAIN). The On-Site Team lead will immediately research each member using our CaseTrakker™ system to determine the members' medical history and care plan and contacts the ALF's manager to obtain the current health status of each member (occurs within 14-20 MAIN). After gathering this information, the On-Site Team lead will: 1) notify the Crisis Team; and 2) brief the On-Site Team. The On-Site Team immediately deploys to the facility (occurs within 15-21 MAIN).

It is MCP's P&Ps that the On-Site Team will arrive at the facility within one (1) hour after initial notification. The On-Site Team lead is responsible for making contact and meeting with the facility manager, and other involved program contractors to get an update of the current situation (occurs within 5-10 minutes after arriving at the ALF - hereinafter referred to as AAAALF). The On-Site Team lead cooperates with all parties involved, including other program contractors to assist in the safe relocation of MCP members. The On-Site Team lead directs our On-Site Team and in collaboration with the ALF's personnel to triage our members according to their service needs. Additionally, if requested by the ALF, the On-Site Team will assist in notifying the members' PCP and the member's family/caregiver<sup>8</sup> of the situation and the members' transfer to a new placement. As part of these activities, the On-Site Team CMs will discuss the next steps with the member and the member's family/caregiver so that they clearly understand the sequence of events (initial attempt to contact will occur within one (1) hour AAAALF). The On-Site Team lead, after reviewing the current transition status of each member, will make arrangements for the transportation and transition of our members to their new placements (occurs within 1-2 days AAAALF).

### ***Initiation of New Placements***

After reviewing the status of each member, the On-Site Team begins a member-centered process to transfer our members to an alternative setting. The On-Site Team coordinates with the members and their families/caregivers to determine the most appropriate alternative placement that supports the members' choice and meets their needs in the least restrictive environment (these steps will occur within two (2) days AAAALF).

Regardless of the member and the member's family/caregiver's choice of setting, the On-Site Team will immediately facilitate the transition. These activities will include but are not limited to:

- Discuss next steps so that members clearly understand what is happening
- Help the member pack their belongings, including any prescribed or over the counter medications
- Review their clinical record to make sure that all medications and clinical care services such as hemodialysis and wound care continue without disruption
- Coordinate with the transferring and receiving facilities

1) MCP's On-Site Team presents to the member and the member's family/caregiver the following placement options:

---

<sup>8</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

- Placement in the family's home with home and community based support services, including offering the family the option to become a paid caregiver
- Transition to an alternative facility in a nearby GSA
- Transition to the nursing facility, if appropriate based on the member needs assessment
- Remain in the facility – an option only available to a total of two members across all Program Contractors<sup>9</sup>

2) Based upon the member's and member's family/caregiver's choice of placement, the MCP On-Site Team will, as appropriate, do one or more of the following:

- Authorize and initiate home and community-based services and other medically necessary support services, as needed
- Complete any additional service authorizations as appropriate
- Arrange for the transfer of DME services, as needed
- Finalize Letter of Agreements with non-contracted facilities
- Arrange for member transport to new placement

### ***Post Transition Monitoring***

Following MCP's SOPs, for any member who was transferred (to a setting other than their family/caregiver's home), there will be post transition monitoring. This post transition monitoring includes; 1) MCP's QM RN will perform an on-site clinical audit with any transitioned member in a new placement within three (3) business days of transition; 2) MCP's CM will also perform an on-site assessment within 10 business days of transition. The purpose of this clinical audit is to review the appropriateness of the member's care plan. Components of this audit include, but are not limited to, review of medication administration and the provision of all physician ordered, medically necessary clinical services. Our QM RNs, immediately after the assessment is completed address any identified issues with the manager/administrator at the new placement. The QM RNs will conduct daily follow-up (telephonically or at the site of the new facility) until the identified issues are resolved. The purposes of the CM assessments are to determine that: 1) all medically necessary services are in place; 2) the member's needs are being met; and 3) the member and the member's family/caregiver are satisfied with their care plan.

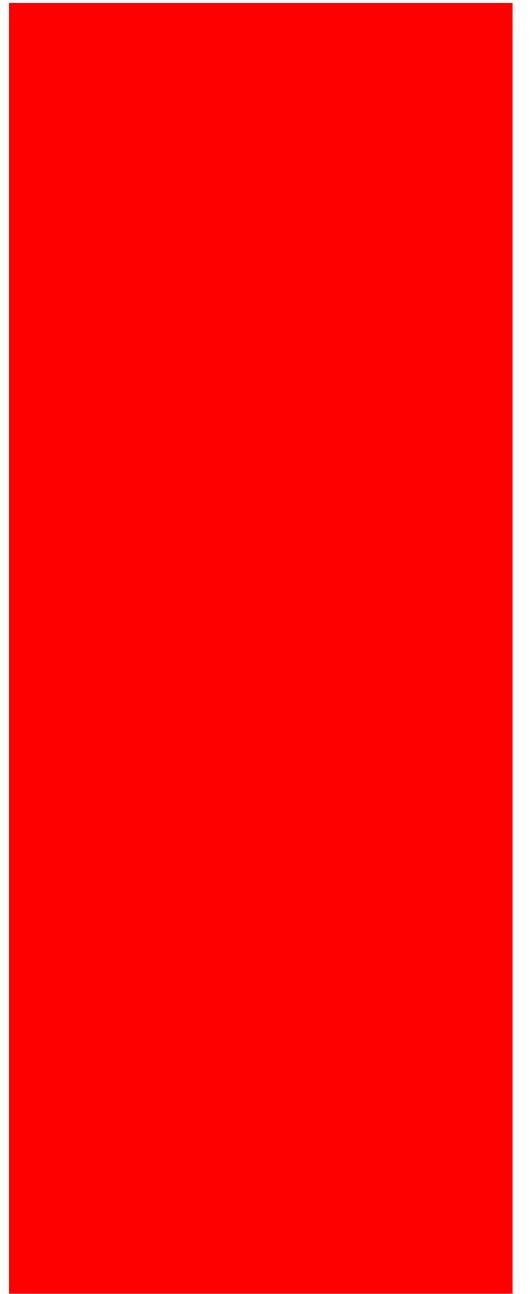
### ***Member Assessment at the Unlicensed Facility***

MCP's provider relations personnel will continue to work with the facility to assist them in obtaining the required operating license. MCP's CMs will increase member monitoring to once every thirty days as long as our members reside in the facility. Should our CM identify any issues or concerns regarding our member's care or safety, the CM will immediately notify MCP's QM and other involved entities (AHCCCS, Adult Protective Services, or Child Protective Services).

---

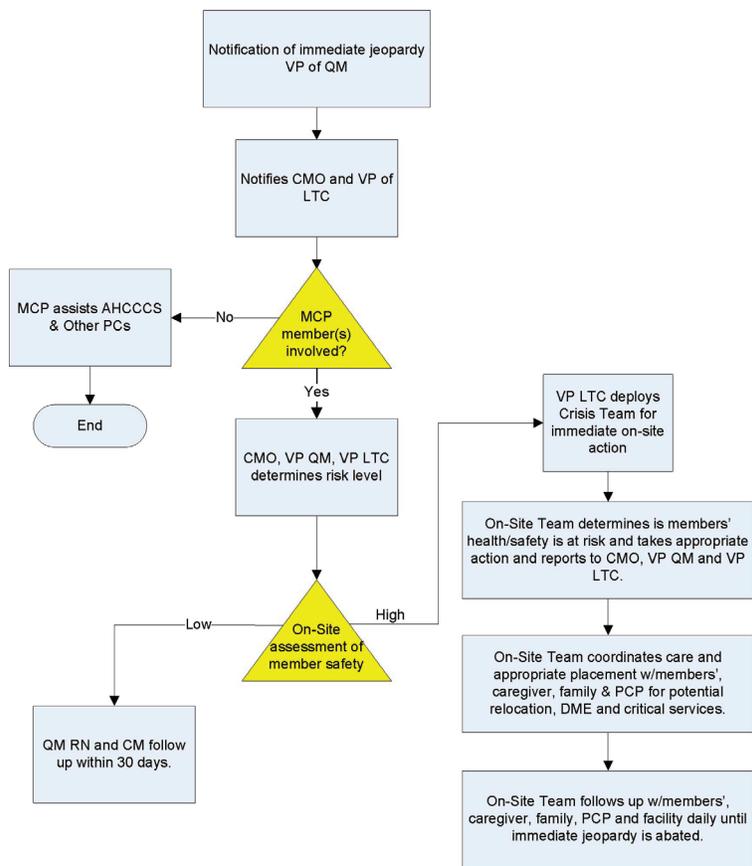
<sup>9</sup> In this instance, the Case Manager will authorize and arrange for home health nursing visits to oversee the members' medical health status. The CM will execute a Managed Care Agreement (MCA) with each member. The purpose of the MCA is to educate the member of the potential risk by remaining in an unlicensed facility and allow them to make an informed choice. The assigned CM will reassess the member's care in the facility at least monthly to determine their safety and if their needs are being met.

31-B



### Question 31 – Quality Management (Case Scenario B)

Mercy Care Plan (MCP) is committed to making sure our members have access to the highest quality of care. Relative to the severity of the complaint, we timely, appropriately, and thoroughly investigate all quality of care concerns. In Immediate Jeopardy (IJ) situations, we have selected the Case Management Administrator/Manager and the Vice President of Quality Management (Quality Management Coordinator) to be available 24 hours-a-day, seven-days-a-week to collaborate with AHCCCS and/or ADHS to resolve IJ situations and AHCCCS has been notified of our selection. The Southwest Catholic Health Network (SCHN) Board of Directors (the Board) has ultimate authority and responsibility for our quality management (QM) program. The Board has delegated responsibility for our QM program to the chief executive officer (CEO). The CEO has delegated day-to-day management responsibility authority to the CMO. The chief medical officer (CMO), with the chief operating officer (COO) has responsibility and authority over our IJ standard operating procedures (SOP). MCP’s IJ written Policies and Procedures (P&Ps) document our standard operating procedures (SOPs) for responding and managing, such incidents and providing protocols to protect the health and safety of our members. Our P&Ps require involvement of personnel from multiple MCP departments to work in collaboration with AHCCCS, ADHS, and other involved program contractors. To protect the health and safety of our members it is our SOP to be at the facility within one (1) hour of notification for each IJ incident. Our IJ Crisis Team (“the Crisis Team”) is deployed to respond to and manage the IJ situation. The CMO has designated the Case Management Administrator/Manager as the lead of our Crisis Team. The Crisis Team includes the Vice President of Quality Management, Case Management Supervisor, Case Managers (CMs); and Quality Management RN(s), Vice President of Member Services, Vice President of Utilization Management, Director of Provider Services, Director of Marketing, and leaders from other departments as needed. The Crisis Team is empowered by the CMO to make immediate decisions to protect the health and/or safety of our members and abate any concerns. The chart below outlines our process for responding to IJ situations.



Following the process described above, MCP responds to Scenario “B” as:

MCP’s vice president of quality management receives notification of the IJ and serves as AHCCCS’ single point of contact. Since this IJ scenario occurs on the Friday before a three (3) day weekend, the VP of quality management will immediately consult our Crisis Team plan (in our SOPs it is mandatory that each member of the Crisis Team is responsible for assigning and receiving an acknowledgement from their alternate, if the Crisis Team member will be unavailable over the holiday or during PTO), and identify if there are alternate personnel. The vice president of quality

management immediately (within 5-10 minutes after initial notification –MAIN) contacts (depending on the day/time and circumstances via in person, email, text message, and telephone call) the CMO or designated medical director and the Case Management Administrator/Manager to review the IJ. Based on the information available, the CMO or designated medical director, in consultation with the VP of Quality Management and the Case Management Administrator/Manager, confirms that this is a high risk situation (within 7-12 MAIN). Based on this decision, the Case Management Administrator/Manager immediately mobilizes (depending on the day/time and circumstances via in person, email, text message, and telephone call) the Crisis Team. At the same time as the Crisis Team is mobilized, the Case Management Administrator/Manager will notify leadership of critical MCP departments (Prior Authorization/Concurrent Review and Provider Services) that the Nursing Facility (NF) is unavailable for new admissions (both steps will occur within 9-15 MAIN).

The Case Management Administrator/Manager, in consultation with the vice president of quality management, will select the On-Site Team lead (occurs within 10-16 MAIN). The Crisis Team lead utilizes the placement roster to identify the MCP members residing at the facility. The On-Site Team lead will immediately research each member using our CaseTrakker™ system to determine the members' medical history and care plan and contacts the NF's administrator or Director of Nursing (DON) to obtain the current health status of each member (occurs within 11-20 MAIN). The On-Site Team lead will be a Long Term Care Manager who is the most familiar with the facility (e.g., the CM assigned to the facility reports in the Long Term Care Manager's span of control). The Case Management Administrator/Manager, the VP of QM, and the On-Site Team lead will select the On-Site Team (occurs within 11-17 MAIN). Personnel from Long Term Care and QM are on-call for crisis situations and as part of their on-call status and, (they are required to identify a substitute if they are unavailable due to the three day weekend or PTO) must be available within 10 minutes to respond to IJ. The On-Site Team lead selects the On-Site Team. The On-Site Team, for this scenario, includes a case management supervisor, five (5) CMs and three (3) QM RNs (occurs within 13-18 minutes MAIN). The On-Site Team lead will immediately research each member using our CaseTrakker™ system to determine the members' medical history and care plan and contacts the NF's administrator or Director of Nursing (DON) to obtain the current health status of each member (occurs within 14-20 MAIN). After gathering this information, the On-Site Team lead will: 1) notify the Crisis Team; and 2) brief the On-Site Team. The On-Site Team immediately deploys to the facility (occurs within 15-21 MAIN).

It is MCP's P&Ps that the On-Site Team will arrive at the facility within one (1) hour after initial notification. The On-Site Team lead is responsible for making contact and meeting with the facility administrator or DON, ADHS licensing staff, local city staff and the Ombudsman, and other involved program contractors to get an update of the current situation and determine if the NF's emergency transfer plan is viable and has been initiated (occurs within 5-10 minutes after arriving at the NF - hereinafter referred to as AAANF). It is MCP's protocol that in these situations, contact with the press is the responsibility of ADHS or the NF. The On-Site Team lead, if required to make a press statement, will follow our SOP and notify our Marketing Department to coordinate any press statement or releases.

The On-Site Team lead cooperates with all parties involved, including other program contractors to assist in the safe relocation of MCP members. The On-Site Team lead meets with facility administrator or DON to determine if: 1) MCP members' placements have been arranged or are in the process of being arranged; 2) any MCP members who have been placed by the NF in a non-contracted facility and completes necessary service authorizations and Letters of Agreement, as appropriate; 3) the NF needs assistance with transportation arrangements or with DME services (occurs within 15-25 minutes AAANF). The On-Site Team lead directs our On-Site Team and in collaboration with the NF's nursing staff to triage our members according to their acuity and service needs. Additionally, if requested by the NF, the On-Site Team will assist in notifying the members' PCP and family/caregiver<sup>10</sup> of the situation and the members' transfer to a temporary placement. As part of these activities, the CM will discuss the next steps with the member and the member's family/caregiver so that they clearly understand the sequence of events (initial attempt to contact will occur within 25-35 minutes AAANF). The On-Site Team lead, after reviewing the current transition status of each member, will offer to assist and support the administrator or DON at the NF in transitioning any MCP members remaining at the facility (occurs within 20-35 minutes AAANF).

### **Post Transition Monitoring**

Once the highest risk members have been transitioned their new placements, an On-Site Team CM will conduct an assessment of these members within two hours. The purpose of these assessments is to confirm that the members' transitions have been completed, the members are safe, and all needs are being met at the new facility. Those members

---

<sup>10</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

who are not considered to be at high risk will be assessed by an On-Site Team CM within 24 hours of transition. The purpose of these assessments is to confirm that the members' transitions have been completed, the members are safe, and all needs are being met at the new facility. The On-Site Team CM also contacts the member's family/caregiver to determine if they have any concerns relative to the transition process (occurs within 10-15 minutes after the assessment) Any concerns of the member or the member's family/caregiver are addressed and resolved by the On-Site Team CM as soon as possible.

Following MCP's P&Ps, for all members transferred there will be post transition clinical monitoring performed by a QM RN from the On-Site Team. A QM RN performs an on-site clinical audit at the new placement within 24 hours for all members. The purpose of this clinical audit includes, but is not limited to: 1) review medication administration; 2) adherence to therapeutic interventions/orders (e.g., dialysis, respiratory therapy, wound care); 3) fall risk assessments; and 4) dietary needs are met. The QM RNs will immediately address any identified gaps in care with the member's PCP, the member or member's family/caregiver and if the member was placed at a new facility, with the facility's administrator and/or the DON. If the member was temporarily placed at home, the QM RN performs an in-home assessment, and during the assessment addresses any identified gaps in care with the member's PCP, assigned CM, and the member or member's family/caregiver. A CM from the On-Site Team conducts daily follow-up (telephonically or at the member's temporary placement) of the member regardless of placement.

The VP of QM will keep AHCCCS informed, as appropriate, on the status of MCP's members (occurs as necessary throughout the IJ). The On-Site Team lead performs daily follow up with the original NF to monitor their progress toward resolving heating, ventilation, air conditioning (HVAC) issues. During these discussions, the On-Site Team lead alerts the original NF of any significant member issues that may affect the member's safe return.

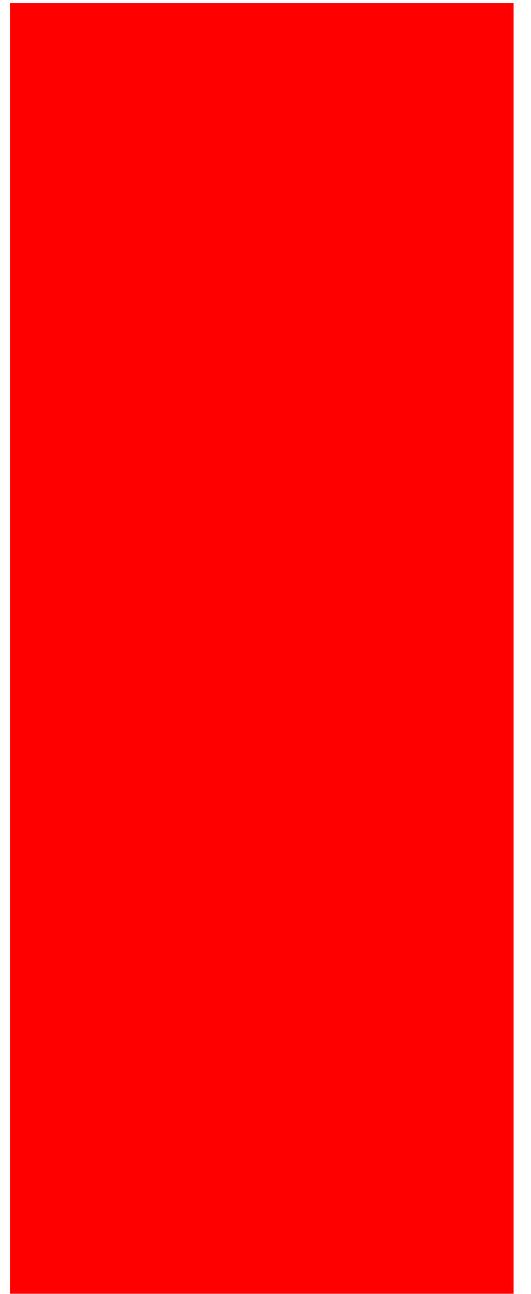
### **Transition Back to the Original NF**

Once the VP of QM receives notice from AHCCCS that the original NF's IJ has been abated, the On-Site Team lead verifies that the facility is safe for our members to return (occurs within one (1) hour after notification of abatement (hereinafter referred to as ANA). The On-Site Team lead, upon verification that IJ has been abated will remobilize the On-Site Team (occurs within two (2) hours of ANA). The On-Site Team CMs will assist the coordination of the member's return by:

- Meeting with each member and the member's family/caregiver to offer the choice to stay at the new placement or to returning to the original NF
  - If the member and member's family/caregiver chooses to remain at the new placement, the On-Site Team lead facilitates all necessary services and authorizations. The CM follows-up with the member and member's family/caregiver within ten (10) days to complete an assessment.
- Assisting, if requested by the original NF, in notifying the members' PCP and other providers of the members' return to the original NF or any change of placement.
- Assisting the member by coordinating with the temporary placement the transfer of the members' medical records, medications, personal belongings and DME or medical equipment (these steps will occur within 24 hours ANA).
- The On-Site Team lead will notify the Crisis Team and all involved MCP departments (Prior Authorization /Concurrent Review and Provider Services) that the facility is now available for new admissions (occurs within one (1) hour of ANA). The QM RN will perform a clinical audit of members within 48 hours of transition back to the original NF. These assessments will confirm that the transitions have been completed, the members are safe, and all member needs are being met at the original NF. The On-Site Team lead and the assigned facility CM will visit the original NF within three (3) business days to assess that our members are safe, secure and that the transition has been completed.

After the On-Site Team lead and the assigned facility CM validates that the transition has been completed, the On-Site Team lead will report to the Case Management Administrator/Manager that the IJ situation has been successfully resolved (occurs within one hour of their return from the NF). The member's assigned CMs will contact the member and the member's family/caregiver to determine if they were satisfied with the transition process and to identify opportunities for strengthening the process (occurs within seven business days of the transition). This information is also provided to the On-Site Team lead as part of our Plan-Do-Study-Act (PDSA) protocols. The On-Site Team lead, the Case Management Administrator/Manager, and the VP of QM will evaluate MCP's overall performance relative to this IJ and report to the QM/UM Committee (occurs within 30 days of final transition). The QM/UM Committee will analyze and evaluate our performance relative to this IJ event and recommend improvements in its' P&Ps and training protocols (occurs within 60 days of the final transition). As part of our commitment to and support of the Nursing Facility Review Collaborative (NFRC), the VP of QM will share the results of our evaluation with other program contractors to identify any potential gaps in the quality review oversight of NF's (occurs within 30-60 days of the final transition).

32.



## **Question 32 – Quality Management**

The Southwest Catholic Health Network (SCHN) Board of Directors (hereinafter referred to as the Board) has ultimate authority and responsibility for our quality management/performance improvement (QM/PI) program. The Board has delegated responsibility for our QM/PI program to the Chief Executive Officer (CEO). The CEO has delegated day-to-day management responsibility and authority to the Chief Medical Officer (CMO). The CMO has responsibility, accountability, and authority for directing the development and implementation of a QM/PI program that continuously evaluates/monitors and improves our members' health outcomes and quality of care provided. MCP's QM/PI program achieved this by choosing and implementing interventions, measuring performance, and considering outcome targets, timing of intervention introductions to produce significant and sustained improvement in both clinical and non-clinical care areas.

MCP has multiple examples of QM/PI improvement strategies that demonstrate our commitment to improving quality of care and performance throughout our organization. These interventions clearly illustrate our capacity and capability to achieve measurable and sustained improvement in delivery of health care services. Our QM/PI processes are member-centered and supportive of members and the members' families/caregivers in achieving and/or maintaining their highest level of self-sufficiency.

### **Comprehensive Diabetes Care (CDC)**

MCP selected Comprehensive Diabetes Care (CDC) as our proposal example. This example clearly demonstrates our commitment to improving quality of care for our members. The CMO with the support of the VP of Quality Management (Quality Management Coordinator) led this effort that required commitment from all MCP's Medical Management, Case Management, and operational units. The CMO recognized the need to improve our CDC performance because of the prevalence of diabetes within our membership and the impact on our members' quality of life and cost to the plan. Therefore, the CMO presented 2006 baseline performance data to the Quality Improvement Committee (QIC) to develop multi-disciplinary strategies to improve healthcare outcomes. The QIC, chaired by the CMO or designee, includes the following multi-departmental personnel: 1) COO; 2) Vice President (VP) of Quality Management (Quality Management Coordinator); 3) Case Management Administrator/Manager; 4) Director of Integrated Case Management (physical and behavioral health); 5) VP of Member Services; 6) Director of Provider Services; 7) Dispute and Appeal Manager; 8) VP of Utilization Management (UM Coordinator); 9) Director of Prevention and Wellness (EPSDT Coordinator); and 10) VP of Health Plan Operations. This committee meets weekly to analyze and determine areas for quality improvement. As a result of these activities, QIC selected CDC based on: a) 2006 baseline CDC performance data; b) members' demographic characteristics and health risks; c) prevalence of diabetes within our membership; d) input from members and members' families/caregivers; e) input from providers; f) utilization management activities; g) trends identified through network/performance monitoring; h) results of credentialing/re-credentialing activities; i) utilization management outcomes; and j) actuarial analysis (predictive modeling).

The QIC applied a measurement and evaluation strategy using the Plan-Do-Study-Act (PDSA) approach to develop, refine, and execute the evidence-based intervention strategies for CDC. The QIC evidence-based interventions were based on: 1) root cause analysis of barriers; 2) claims and encounter data analysis; 3) review of evidence-based literature; and 4) input from MCP's Member Advisory Council (MAC). Through this strategy, the CMO was able to demonstrate and communicate results throughout the organization by identifying successes and recognizing areas that needed additional attention or possible revision. This feedback and adjustment approach enabled the CMO to reinforce and systematically improve the commitment of the involved units and their personnel through positive. For instance, one of our intervention strategies was to implement a PCMH program for members residing in NFs and ALFs. Through this process we recognized the value of expanding the PCMH program to members residing at home. This contributed to our success in improving diabetes screening rates in 2009. Following the Board's vision, the QIC developed, evaluated, and monitored intervention strategies that resulted in improved performance in CDC.

### **Evidence-Based Intervention and Improvement Strategies**

The QM/UM Committee, after reviewing the recommendations from the QIC, developed a multi-faceted, comprehensive, and innovative evidence-based interventions and strategies to improve members' health outcomes and quality of care through increasing our performance relative to CDC. These evidence-based interventions and improvement strategies required the commitment of MCP's Medical Management, Case Management, and operational units. Each unit had a defined responsibility and was accountable for performance that contributed to the successful implementation of CDC interventions. We support these processes by: 1) engaging our members, members' families/caregivers; 2) involving the members' primary care providers (PCPs); and 3) cross-functionally collaborating with MCP's: a) Case Managers (CMs);

b) quality management (QM); c) network development/provider services; d) member services; and e) medical management (prior authorization, concurrent review, retrospective review). These interventions included: 1) a flexible Patient-Centered Medical Home (PCMH) program with pay-for-performance (P4P) incentives specific to CDC performance; 2) an enhanced communication program to inform PCPs of members on their rosters with identified gaps in care; QM RNs then reinforced this communication using face-to-face meetings with high volume providers; 3) an applied member-centered outreach and education program administered by CMs for members with identified gaps in care; 4) expanded network for vision services in order to improve access to care; and 5) implemented ActiveHealth Care Considerations to members and providers. As part of our consistent and ongoing efforts to improve CDC, the CMO is finalizing the development of a PCMH for diabetic members with a large clinic provider.

Intervention	Responsible Entity	Activity
PCMH program	Provider Services, and CMs	<ul style="list-style-type: none"> <li>Monthly PCP visits, including in-home visits</li> <li>P4P to improve CDC measures</li> </ul>
Enhanced provider communication program	QM/PI, Provider Services	<ul style="list-style-type: none"> <li>Monthly report sent to PCPs identifying members with CDC gaps</li> <li>QM RN on-site PCP visits for education (Evidence-Based Clinical Practice Guidelines pertaining to diabetes) and CDC gap review</li> </ul>
Member-centered outreach	QM, Case Management, Member Services	<ul style="list-style-type: none"> <li>Quarterly (AHCCCS approved) letters to members advising of CDC gap including educational materials from the American Diabetes Association</li> <li>CMs during quarterly in-home assessments reinforce diabetic education and identify CDC gaps for the member to discuss with their PCP</li> </ul>
Vision network expansion	Provider Services, Utilization Management	<ul style="list-style-type: none"> <li>Contracted with a new vision provider who had a retinal eye exam program in place</li> <li>Provided the new vision vendor a list of members with a CDC gap to schedule an appointment</li> <li>New vision provider conducted on-site retinal eye exams at NFs</li> </ul>
ActiveHealth Care Considerations	Provider Services, Utilization Management, Case Management	<ul style="list-style-type: none"> <li>Implemented monthly provider and member targeted communications/educations identifying gaps in care</li> <li>CMs during quarterly in-home assessments reinforce diabetic education and identify CDC gaps for the member to discuss with their PCP</li> </ul>
Planned Intervention	Responsible Entity	Activity
Diabetes focused PCMH program	QM, UM, Provider Services, Member Services, Case Management	<ul style="list-style-type: none"> <li>PCP led holistic program including diabetic educators, nutritionists, and community liaisons</li> <li>Telehealth monitoring for high-risk members identified as high risk for hospitalization and ED visits</li> </ul>

MCP’s multi-faceted, innovative, and multi-interdisciplinary approach, coupled with responsive inter-departmental commitment was instrumental in achieving our improved CDC performance. It is our experience that influencing behavior changes in ALTCS members and the members’ families/caregivers and their PCPs required the clear articulation of expectations to PCPs regarding adherence to Evidence-Based Clinical Practice Guidelines, and to members and members’ families/caregivers regarding the adoption of healthy lifestyles and increasing engagement in managing their own healthcare. To improve the effectiveness of our interventions, these messages were constantly repeated and reinforced through our PCPs, CMs, QM RNs, and other providers.

The Board held the CEO and the CMO directly responsible for MCP’s performance on this performance measure. The CEO and the CMO jointly developed approaches to communicate with and assess the performance of each department. Performance management and reporting became a routine and systematic way for MCP’s departments to share in successes, recognize achievements, and resolve barriers to accomplishing goals. This collaborative experience resulted in a strong and resilient commitment to and support for the CDC interventions through MCP’s Medical Management, Case Management, and operational units.

CMs are pivotal in the implementation and execution of these interventions. CMs receive initial and annual training relative to the elements of the CDC interventions. The purpose of this training is to prepare the CMs for implementation and execution of the interventions during the member-centered quarterly assessments. The CM’s annual performance evaluation includes an assessment of his/her performance as it relates to their assigned member’s improvement in CDC.

Presented in the table below is a summary result of our diabetes screening performance:

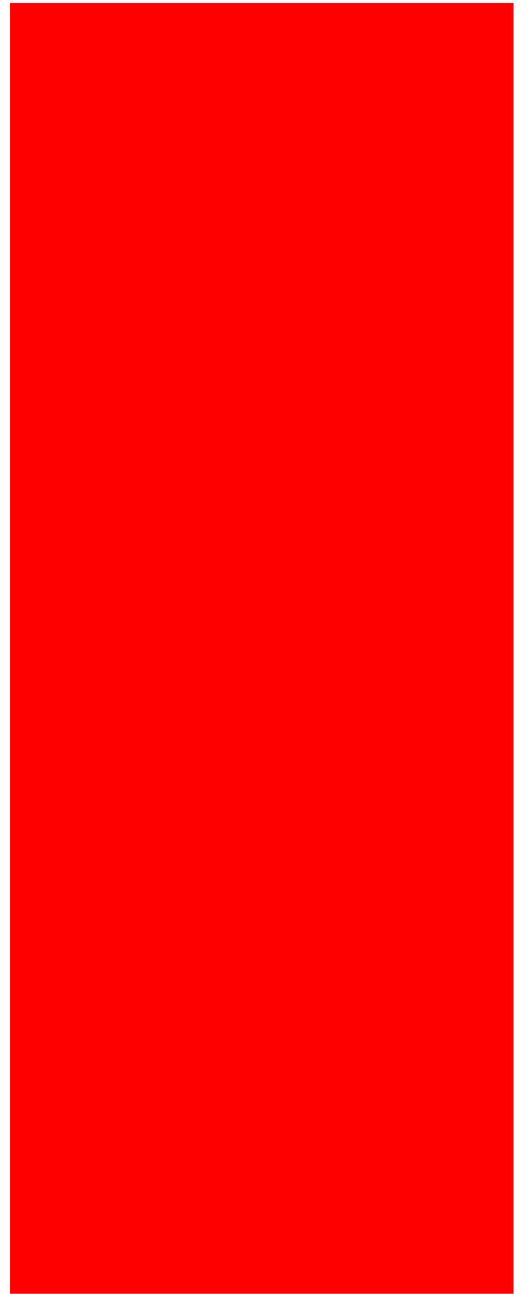
**Summary of MCP’s Diabetes Screening Performance 2006 - 2009**

Measure	2006	2007	2008	2009	ALTCS Statewide Avg	ALTCS Goal
Diabetes HbA1C rate	82.2%	87.3%	88.7%	90%	86.6%	89%
Diabetes LDL-C testing	80.6%	82.8%	85.7%	88%	77.9%	91%
Retinal eye exam	52.3%	67.5%	68.2%	75.4%	63.9%	68%

As indicated in the table and the interventions described above, it is clear that MCP is supporting the mission, vision, and values of our Board. MCP evaluated each intervention independently and then combined the analysis to determine the overall impact of the interventions on CDC. Analysis of these data supports our conclusion that the interventions were successful in achieving the desired outcomes related to diabetes screening. MCP’s diabetes screening performance is a strong indicator that overall CDC intervention results have positively impacted our members’ health outcomes and quality of care. Based on an analysis of our outcomes and the involvement of multiple departments across our organization, it is evident that our commitment to improving the quality of healthcare and performance measures is spread throughout our health plan. Furthermore, MCP is committed to continual improvement of the quality of care and enhancing our capability of delivering high quality, member-centered healthcare services.

MCP’s multi-faceted and inter-departmental interventions have showed that working cooperatively with PCPs, aligning PCP incentives, and encouraging/supporting members (and members’ families/caregivers) to become engaged in their own healthcare can improve health outcomes and quality of care. One of MCP’s priorities is to provide each member with the right service, at the right time, at the right level of care and our experience with these interventions demonstrates the effectiveness of this priority.

33.



### Question 33 – Quality Management

Mercy Care Plan (MCP) applies the Plan-Do-Study-Act (PDSA) approach to our process for receiving, categorizing, analyzing, and acting upon feedback from both members and providers. Our PDSA approach involves leadership from throughout MCP’s entire organization. The Southwest Catholic Health Network (SCHN) Board of Directors (hereinafter referred to as the Board) has ultimate authority and responsibility for our Quality Management and Performance Improvement (hereinafter referred to as QM/PI) program. The Board has delegated responsibility for our QM/PI program to the Chief Executive Officer (CEO). The CEO has delegated day-to-day management responsibility and authority to the Chief Medical Officer (CMO). The CMO has responsibility, accountability, and authority for directing the development and implementation of the QM/PI program. Our QM/PI program receives feedback from our members and providers to continuously improve our programs, operations, and management approach. These program, operational, and management improvements lead to enhanced member health outcomes and efficiency of provider services.

MCP values feedback from our members and providers as necessary and important information about our clinical and non-clinical programs. Members are a source of critical information about our processes to help our members navigate the complex health care system, improve the accessibility and availability of services, and enhance quality of care. Our providers also serve as an important source of information in our continual efforts to enhance our level of service to members and providers. Key information we learn from our providers is used to improve prior authorization, formulary management, claims processing, and other vital functions.

MCP keeps our members and providers informed in reference to how to contact us. MCP uses the following communication tools to inform our members and providers about how to submit feedback to us:

Member Communication	Provider Communication
Member Website	Provider Web Portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Department Staff	Provider Services Representative (Toll free call)
Care Plan	Care Plan
Member Call Center (Toll free call)	Provider Service Center
UM/PA – Notice of Action Letter	UM/PA – Service Approvals/Denials

### Member and Provider Feedback

MCP recognizes that there are multiple ways to receive member and provider feedback. The points of member and provider contact with MCP for feedback are identified below.

Member Feedback	Provider Feedback
Member Interaction with Assigned Case Manager (CM)	Provider Satisfaction Survey
Member Grievances/Quality of Care Issues	Provider Services Representative Contact
Member Satisfaction Surveys	Provider Assistance Program for Non-Compliant Members
Transportation Surveys	A Provider Claims Educator
Member Advisory Council	Joint Operating Committees
Staff Feedback	Provider Turnover
Regulator Input	Provider Complaints and Appeals
	Provider Site Visits
	Staff Feedback.
	Identifying and Coaching Physician Groups with High Panel Use of ER
	Provider Group Meetings

### Process to Drive Change or Improvements

MCP incorporates member and provider feedback into our QM/PI activities to drive operational changes to improve clinical and non-clinical programs. MCP’s operational departments have responsibility for addressing specific member and provider issues as they arise. For instance, for member issues reported by members into the Member Services Department, the Vice President of Member Services is responsible for directing the process to identify, analyze, resolve, and report. For provider issues reported by providers into the Provider Services Department, the Director of Provider Services is responsible for supervising the process to identify, analyze, resolve, and report. Other departments who

receive member or provider feedback follow a very similar process. Every operational department with responsibility and authority for collecting either member or provider input reports to the Chief Operating Officer (COO). Every medical department with responsibility and authority for collecting either member or provider input reports to the CMO. The COO and the CMO are responsible for the consistent, reliable, timely, and complete identification, analysis, resolution, and reporting of member and provider feedback trends to the Quality Improvement Committee (QIC).

The QIC, chaired by the CMO or designee, includes the following multi-departmental personnel: 1) COO; 2) Vice President (VP) of Quality Management (Quality Management Coordinator); 3) Case Management Administrator/Manager; 4) Director of Integrated Case Management (physical and behavioral health); 5) VP of Member Services; 6) Director of Provider Services; 7) Dispute and Appeal Manager; 8) VP of Utilization Management (UM Coordinator); 9) Director of Prevention and Wellness (EPSDT Coordinator); and 10) VP of Health Plan Operations. This committee meets weekly to analyze and determine areas for quality improvement.

The QIC receives from MCP's operational, case management, and medical departments monthly, quarterly, and annual member and provider feedback, complaints, and survey results to identify patterns and trends. In addition to reviewing each report, the QIC evaluates whether the same themes appear across multiple data sources, thus allowing it to identify trends and prioritize improvement activities. The QIC makes recommendations to manage and improve the network, tracks implementation on the QIC action plan, and monitors each project through to completion. The QIC reports its findings and recommendations related to monitoring activities to the QM/UM Committee.

The QIC is our principal forum to systematically identify, discuss, and resolve feedback, complaints, and survey results that impact both members and providers. It reviews trended data, approves recommended intervention activities, identifies additional improvement activities, assigns action plans, and monitors the action plans to completion.

The QIC uses member and provider feedback, complaints, and survey results information to make recommendations regarding provider training, employee training, operational improvements, or policy changes.

Similar to the QIC, the QM/UM Committee is an interdisciplinary committee comprised of Vice Presidents and Directors from various MCP departments and network providers that review data and monitoring results, and make and monitor progress related to recommendations with regard to interventions that help manage and improve the network. The Peer Review Executive Session of the QM/UM evaluates quality of care concerns and recommends actions to the CMO.

### ***How MCP Used Member Feedback to Drive Change***

***Adding an additional transportation provider to our network resulted in a 5 percent reduction in transportation complaints from the previous year.***

Based on trends identified from member grievances and transportation surveys, we continually review all transportation delays and appointment/transportation no shows for quality of care referrals to the QM Department. The QM Department reviews each event to determine if it is appropriate to initiate a quality of care investigation. These investigations identified trends related to transportation delays affecting members on dialysis arriving timely for their scheduled appointments. In addition, MCP's Member Services Department conducts telephone surveys based on a statistically significant random sample of members who requested transportation services the previous day. The purposes of the survey are to: 1) survey members about their satisfaction with the quality and timeliness of transportation services; 2) verify that the member actually received the service, which assists in the identification of potential fraud; and 3) measure whether transportation providers are meeting the AHCCCS transportation time standards.

As a result, the QIC reviewed the quality of care trends in conjunction with the Member Services Department transportation survey results and prioritized transportation needs for our members on dialysis for improvement. The QIC recommended that MCP contract with a special transportation provider to improve transportation services for our members on dialysis. This intervention resulted in a significant reduction of transportation related quality of care concerns (QOCs) and improved member satisfaction as indicated through survey results.

### ***How MCP Used Provider Feedback to Improve Claims Payment***

Our COO, along with MCP's leadership team has used provider feedback as an opportunity to create process improvements aimed at addressing issues of importance to providers. Based on feedback, we have re-designed our Provider Services Department and developed various interdepartmental workgroups, each with the skills and authority necessary to resolve provider concerns in a timely and effective manner. These workgroups have been very effective in improving operations in response to provider concerns. Below is a description of the workgroups MCP has created to respond to provider feedback and how they have driven improvements in operations. Through its routine review of



provider grievances, MCP identified the need to improve communication with providers related to claims payment. In response, MCP developed a Health Plan Operations (HPO) Department that is responsible for claims research and resolution; reviewing product requirements and system configurations; managing provider records and encounter files; and reporting.

MCP has re-engineered the Provider Services Department to provide additional provider services staff and a more organized focus on individual provider needs. The Provider Services Department includes a Vice President, Director, Managers, and Provider Services Representatives (PSRs) who support contracted providers. MCP has reassigned PSRs based on provider specialty designation rather than geographic location, giving them a better knowledge-base of regulatory requirements and payment considerations, claim trends that may occur in a given specialty, and understanding of physician practice patterns. In addition, the department includes dedicated staff for network development and contracting, project management staff to assist with business planning, regulatory and internal reporting, and operations staff to assist with higher level claim research projects and provider settlements.

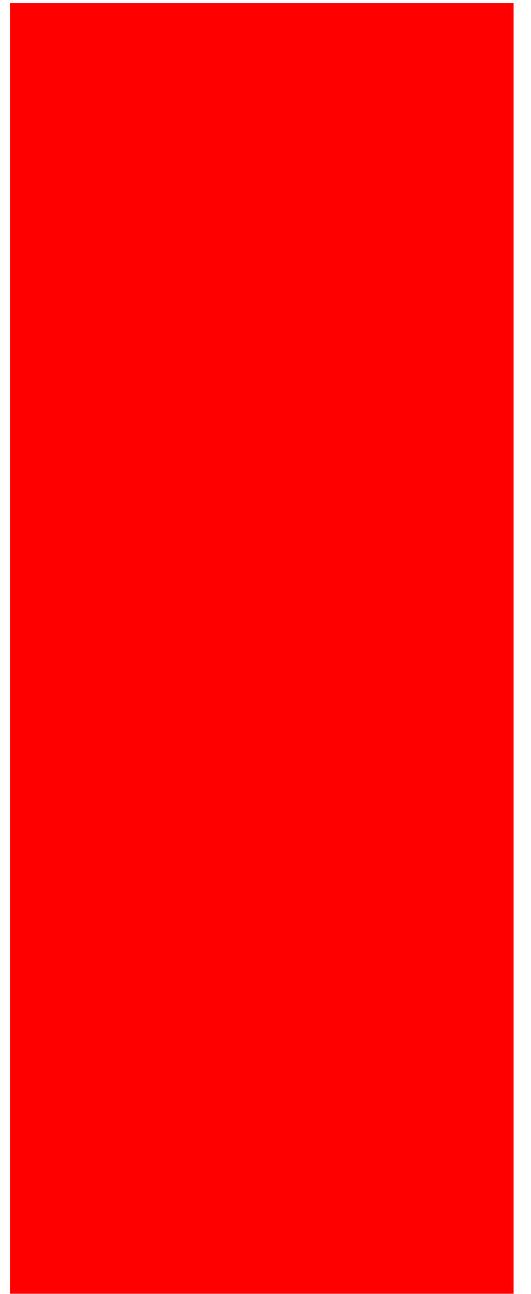
PSRs keep in close contact with providers and visit PCPs a minimum of three times a year; obstetricians, and dentists twice a year; specialists once a year; hospitals and ancillary providers monthly. We also conduct additional ad hoc visits as necessary. PSRs encourage providers to discuss issues of individual concern with the goal of resolving them as they occur. For example, PSRs work with providers immediately upon learning that a provider may want to terminate their contract and actively address complaints or inquiries from providers. PSRs conduct appointment availability audits during visits and provide real-time education to noncompliant providers.

As a result of this approach, MCP has experienced low rates of provider turnover, provider complaints, and noncompliance with appointment availability standards. Our MCP provider satisfaction scores are high and outperform the benchmark score for other Medicaid plans. We anticipate further increases in provider satisfaction as we continue to make further improvements.

Through root cause analysis, MCP identified that many claims issues were due to inconsistent and inaccurate provider data housed in our system. As a result, the HPO Department launched an effort in November 2009 to clean up provider data. Previously, MCP cleaned up provider data on a case-by-case basis in response to issues rather than undergoing a proactive effort to verify accuracy. To date, this project has proactively identified and corrected many provider changes, which improves claims accuracy and reduces the amount of changes necessary on a retroactive basis. To improve ongoing accuracy, MCP implemented a quality control process and streamlined interdepartmental communication by creating a database to store provider data information. The project remains ongoing, with next steps to include refining provider directory information and automating provider file updates to remove manual errors.

MCP's improved performance is evident on the Acute Care Contract Quarterly Audit Report that MCP submits to AHCCCS. The report indicates that claims accuracy and grievance system timeliness continue to improve throughout 2010, and audit scores consistently exceed target.

34.



## **Question 34 – Quality Management**

Mercy Care Plan (MCP) has a comprehensive program to monitor services and service sites for our members that reside in their own home. Our monitoring program has been in existence since 2000 and it has been continually upgraded to meet community and AHCCCS standards. The services and service site monitoring program is administered by our Quality Management Department. MCP, in monitoring services and service sites, applies standardized assessment tools to monitor, evaluate, and improve the quality, safety, and consistency of member care. The purpose of this monitoring program is to evaluate services and service sites to assure that each member receives quality, appropriate and timely services in accordance with the member's care plan. Quality of Care (QOC) trends are referred to the QM/UM Committee to identify opportunities for improvement in the delivery of services to our members and in our service delivery system, including but not limited to developing a performance improvement project (PIP).

The Southwest Catholic Health Network (SCHN) Board of Directors (hereinafter referred to as the Board) has ultimate responsibility and oversight of MCP's Quality Management (QM) program. The Board delegated responsibility and authority for the QM program to MCP's Chief Executive Officer (CEO); the CEO delegates day-to-day responsibility and authority of the QM program to the Chief Medical Officer (CMO). Under the direction of the CMO and supported by the Vice President of QM (Quality Management Coordinator), the MCP QM Department is responsible to develop and implement the monitoring program. The MCP QM Department has written Policies and Procedures (P&Ps) that govern the processes and protocols for performing monitoring of services and service sites for members residing in their own homes. In performing these functions, the QM Department focuses on the health and safety of our members and coordinates efforts to improve the consistency and quality of care, so the member continues to reside safely in their own home.

In keeping with the ALTCs guiding principles of consistency of services and maintaining the member in the most integrated setting, our monitoring process is designed to assess all in-home services, including but not limited to attendant, personal and respite care, homemaker, and home delivered meals. In addition, when we monitor service sites such as adult day care centers or primary care physician (PCP) and specialist offices, the focus of our assessments is on consistency of services, and accessibility of providers.

### **Comprehensive Monitoring Program: Patient Centered Medical Home (PCMH)**

The QM Department applies and has continually improved an AHCCCS approved standardized protocols for monitoring services and service sites for members residing in their own home. A QM RN, reporting to the VP of quality management, performs an annual assessment of each contracted PCMH PCP who serves members through "in-home" visits at the member's placement (NF, ALF or the member's home). In performing this assessment, the QM RN uses a standardized monitoring tool that consists of multiple standards for review and verification. The QM RN must attend and successfully complete training regarding in-home services, MCP's P&Ps, Evidence-Based Clinical Practice Guidelines, medical record abstraction, and the use of the Assessment Tool. The components of the assessment include but are not limited to: 1) the provider's P&Ps; 2) documents within the provider's personnel files (certifications in CPR and first aid and three references from former employers); 3) evidence of a member satisfaction survey; 4) documentation of timeliness of services; 5) documentation of contingency plans; a) for the provider; b) for the member; 6) service gap documentation; and 7) documentation of provider supervisory visits to verify effectiveness of services.

The QM Department's quality monitoring program includes elements that are designed to assess attendant care, personal care, homemaker, and respite care. Specific factors for each service are audited. In monitoring attendant care, our review and verification includes, but is not limited to: 1) that the contractor had interviewed attendant care applicants within 14 days of the applicant contacting the contractor; 2) that a written agreement, signed by the member, which delineates the worker's responsibilities is part of the member's case file at the provider's office; 3) the member's case file at the provider's office includes records of on-site supervisory visits; 4) the contractor's attendant care employee files includes records of training and evaluation of each attendant employee, including immediate family members as paid attendant caregivers; and 5) the contractor's attendant care employee files includes records of specialized training for each attendant caregiver to provide necessary services to members (e.g., Alzheimer's or cognitive disabilities).

In our annual monitoring of personal care providers, our review and verification includes, but is not limited to: 1) that each personal care employee's file includes documentation that the personal care employee was under the direct supervision of an experienced and qualified personal caregiver until the personal care employee was determined competent in each necessary skill; 2) that each member's case file at the provider's office includes a copy of the individualized care plan for personal care to confirm inclusion of duties and tasks necessary for maintaining the member's self-sufficiency (e.g., bathing, dressing, transferring, grooming, toileting, and feeding); and 3) documentation in each



member's file at the provider's office demonstrates evidence of timely and complete supervisory visits at the member's home.

In our annual monitoring of homemaker service providers, our review and verification includes, but is not limited to: 1) documentation in the member's case file at the provider's office includes a completed individualized care plan that delineates homemaker task, including: a) laundry; b) cleaning to maintain a safe and sanitary living environment; c) meal planning, shopping, and preparation to meet the member's nutritional needs; e) other duties and tasks as described in the individualized care plan; and 2) documentation in the member's case file at the provider's office that demonstrates evidence of timely and complete supervisory visits.

In our annual monitoring of respite care service providers, our review and verification includes, but is not limited to: 1) documentation in the respite caregiver's personnel file that indicates training and evaluation; 2) documentation in the member's case file at the provider's office of the member's individualized care plan; and 3) documentation in the member's case file at the provider's office of on-site supervisory visits of respite caregivers.

### **Comprehensive Monitoring Program: Service Sites**

MCP's comprehensive monitoring program for members' in-home services is based on reviewing and verifying documentation for attendant care, personal care, homemaker, and respite care for each contracted service provider. MCP annually audits these contracted service providers and selects a sample of member records from each provider to complete the monitoring process.

#### ***Ambulatory Medical Record Review (AMRR)***

MCP has P&Ps regarding initial and ongoing (every three years) monitoring of provider medical records at primary care providers (PCPs), Obstetricians/Gynecologists, and those specialists with 50 or more referrals per contract year. In performing the initial and ongoing monitoring of provider medical records, our QM RN personnel use our AHCCCS approved AMRR tool. The AMRR is a standardized assessment tool to monitor compliance with MCP's medical record P&Ps, as well as compliance with MCP's Evidence-Based Clinical Practice Guidelines. The results of the AMRR are reviewed and shared with the provider at the conclusion of the audit to assist the provider in improving adherence to medical record documentation and Evidence-Based Clinical Practice Guidelines. All results are submitted to MCP's QM/UM Committee for review and approval or recommendations for potential corrective actions. The CMO, as appropriate, reports findings to the Board.

#### ***Behavioral Health (BH) Service Site***

MCP contracts with several BH agencies that provide in-home BH services (e.g. counseling, family support) to our members. Our QM RN conducts on-site monitoring of each contracted BH service provider annually using an AHCCCS approved, standardized monitoring tool. Additionally, the QM RN reviews the agency's Arizona Department of Health Services license file. The QM RN samples our members' medical records at the BH agency to complete the agency's review and determine compliance with MCP P&Ps, Evidence-Based Clinical Practice Guidelines and AHCCCS requirements. The QM RN, at each agency, uses our standardized tool to review documentation that includes, but is not limited to: 1) documentation of an initial screening/evaluation in the member's medical record; 2) documentation of medical orders in the member's medical record; 3) documentation of medication administration in the member's medical record; 4) documentation of each service provided in the member's medical record; 5) documentation of evaluation of the member's progress in the member's medical record; and 6) documentation of coordination of care with the member's PCP in the member's medical record. All results are submitted to MCP's QM/UM Committee for review and approval or recommendations for potential corrective actions. The CMO, as appropriate, reports findings to the Board.

#### ***Home Delivered Meals and Adult Day Sites***

MCP has a fully delegated agreement with an organization to provide home delivered meals and adult day health services. This AHCCCS approved fully delegated agreement includes delegation of service provision and service monitoring responsibilities. The QM RN performs an annual on-site audit of each delegated entity. The QM RN oversees the performance of each delegated organization, including, but not limited to: 1) an annual on-site audit of the delegated entity's monitoring program to include its P&Ps, reports of their assessments, and all personnel files; 2) quarterly review of monitoring reports submitted by the delegated entity of all member grievances and self investigations conducted; 3) tracking results of monitoring and Quality of Care (QOC) investigations provided by the delegated entity to reflect any trends in the QOC; and 4) as necessary review of Corrective Action Plans (CAPs) implemented by the delegated entity. All results are submitted to MCP's QM/UM Committee for review and approval or recommendations for potential corrective actions. The CMO, as appropriate, reports findings to the Board.

## **Case Managers' (CM) Role**

MCP's Long Term Care CMs supplement and support our comprehensive monitoring program. CMs work closely and cooperate with our QM Department by performing ongoing monitoring of all in-home services for their assigned members. The QM Department provides training to the CMs relative to performing these responsibilities. CMs can also contact the VP of QM or a QM RN for additional guidance and assistance. The CM's responsibilities in performing these tasks include, but are not limited to: 1) soliciting member and family input on the quality and accessibility of in-home services during each assessment; 2) developing a contingency plan in conjunction with the member and the member's family/caregiver<sup>11</sup>; 3) reviewing service plans for continuity of care and progress toward service outcomes; 4) reporting potential QOC's to the QM Department; and 5) identifying and reporting risks to the QM Department and /or the appropriate agency (e.g. AHCCCS Fraud and Abuse, APS, CPS). The CMs findings are documented in CaseTrakker™ that the QM Department personnel has access to. The CM is trained to take immediate and appropriate action to address urgent situations when a member's health or safety is in jeopardy.

## **Corrective Action Plan (CAP) Process**

MCP has P&Ps governing CAPs, including how they are implemented, administered, and monitored. The CMO, with support from the VP of QM has responsibility for the program to monitor services and service sites of members who reside in their own home and to take the appropriate and necessary steps when providers are out of compliance with standards. If during or as a result of a site-visit audit, the QM RN determines there is an immediate QOC concern, the QM RN will immediately (while at the service provider site) alert the CMO and the VP of QM and initiate action to protect the health and safety of our member.

The CAP steps are as follows: 1) the QM RN, as part of the routine exit interview, reviews the preliminary results of the audit with the entity; 2) the QM RN finalizes and scores the standardized audit tool within 14 working days or as soon as possible if there is indication that the entity will fail; 3) if the entity a) "passes" (in order to pass, the entity must have a score of 80 percent or greater on all audit factors) the audit, the QM RN submits the audit results to the VP of QM; the VP of QM will notify the entity and the CMO; the CMO reviews the audit results with the QM/UM Committee; or b) "fails" (received less than a passing score of 80 percent or greater) the audit, the QM RN notifies the VP of QM and the CMO or the CMO's designee of the need for a CAP; 4) if a CAP is required, a) the VP of QM notifies the entity via certified mail that a CAP must be developed and submitted that is specific to the deficiencies noted in the audit report; and b) as part of this notification and based on the severity of the deficiencies, the VP of QM requires the entity to submit the CAP within a specified time period; 5) upon receipt of the CAP, the QM RN and the VP of QM, in consultation with the CMO or designee review the appropriateness and responsiveness of the entity's proposed CAP to the original request; 6) if: a) in the event that the CAP is "accepted" by the VP of QM, the entity is notified via registered mail of the acceptance and that their performance will be monitored by the QM RN as appropriate; or b) in the event that the CAP is "rejected" by the VP of QM, the entity is notified via registered mail that it's proposed CAP was either unresponsive or inconsistent with MCP's initial CAP and timeline request; and c) the VP of QM, as necessary, may provide technical assistance to the entity in successfully developing their CAP; d) if after the entity receives technical assistance in preparing their CAP and the CAP re-submission is repeatedly unacceptable (a maximum of three submissions is normally allowed), the VP of QM will recommend to the CMO immediate termination of the provider's contract and will: i) notify CM, member services, and provider services to begin transition of members; ii) advise the QM/UM Committee of the recommended action; iii) follow standard operating procedures regarding the peer review and a fair hearing process for PCPs and specialists; and iv) notify AHCCCS and all required regulatory authorities; 8) the entity's performance against the CAP is monitored in accordance with guidance by the VP of QM when the CAP was accepted; 9) the VP of QM documents all monitoring activities, including but not limited to, those relative to an entity "passing" or "failing" the monitoring process and if appropriate resultant CAP; 10) the CMO advises the QM/UM Committee of all corrective actions for review and approval; and 11) the CMO advises the Board of all corrective actions.

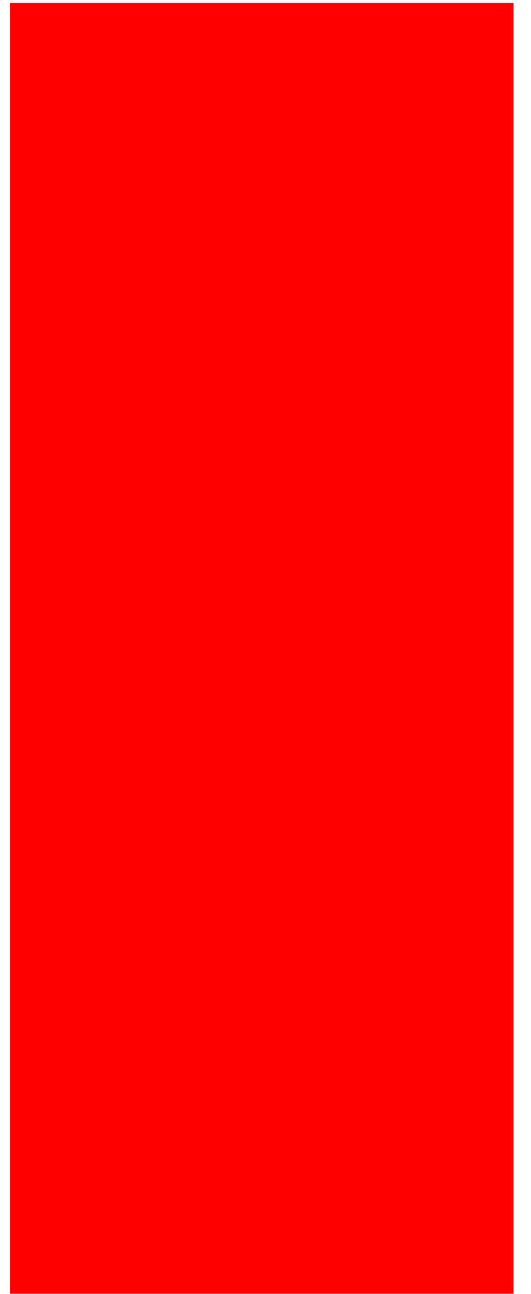
This process is a core competency for MCP. MCP has, through its continued efforts has noted an improvement in services and service sites for members that reside in their own home. For instance, attendant caregiver training has improved as well as we have documented an increase in supervisory oversight by for attendant care, personal care, homemaker and respite providers. Our continuing emphasis during the audit process has resulted in an improvement of the completeness and accuracy of member's case files.

---

<sup>11</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

Oral Presentation

35.

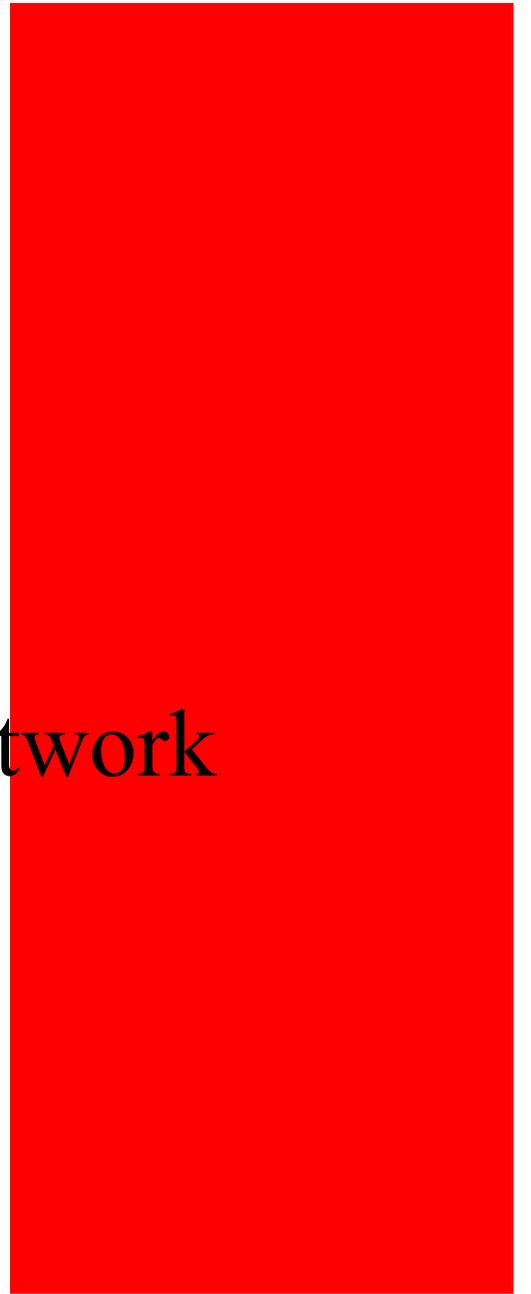




### **Question 35 – Oral Presentation**

Mercy Care Plan (MCP) will comply with the request for documentation identifying the names and resumes of the individuals participating in the oral presentation by 3 p.m. MST on April 8 via the AHCCCS EFT/SFTP server. The documentation will indicate if the individual is employed or contractor/consultant of MCP and what their role will be during the implementation phase and the first year of the contract.

## E. Provider Network

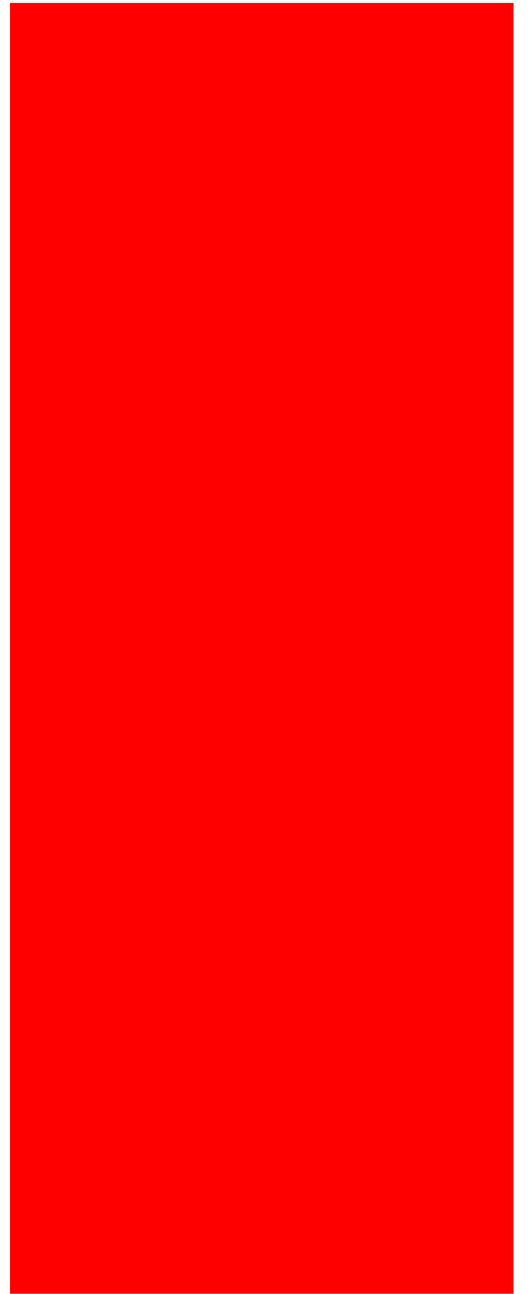




## E. PROVIDER NETWORK

Table of Contents	
Section	Page #
<b>Provider Network</b>	
Question 36	205
Question 37	300
Question 38	303
Question 39	306
Question 40	309
Question 41	312
Question 42	315
Question 43	317
<b>Corporate Compliance</b>	
Question 44	320
<b>Network Summary via EFT/SFTP</b>	
Question 45	323

36.



### Question 36 – Provider Network

Mercy Care Plan (MCP), established in 1985 as a not-for-profit corporation, was one of the first health plans to offer services to AHCCCS acute, long term care, Health Care Group, and Developmentally Disabled members. We also serve Arizonans' eligible for both Medicare and AHCCCS as a Medicare Special Needs Plan (SNP) – a unique type of Medicare Advantage Plan that CMS regulates which requires MCP to offer a comprehensive network of providers in Maricopa, Pima, and Santa Cruz Counties. In each of these programs MCP successfully develops, manages and directs a complete, responsive, quality, and member-driven network. This network includes: 1) primary and specialty care providers; 2) behavioral health services; 3) hospitals; 4) ancillary providers; and 5) other providers to serve each member, including ALTCS members. We apply this distinctive experience to our ALTCS Network Development and Management Plan (Plan). MCP, through its dedicated local hospital owners and highly qualified staff has proven over the last 10 years that it is well qualified and able to address the specialized needs of ALTCS members in the Maricopa General Service Area (GSA). Relative to our expansion into the Pima and Santa Cruz GSA MCP is well positioned to leverage our current relationships with the provider community and demonstrate our capacity to serve the current and expected enrollment growth. The Plan, attached, meets or exceeds AHCCCS' requirements and specifications. It demonstrates how we provide each member with a choice of providers and accessibility and availability of services, resulting from our collaboration with members, providers, and community agencies.

MCP coordinates, manages, directs, and provides acute care, long term care, behavioral health, and case management services to each ALTCS member regardless of their residence, special health care or chronic care needs. Our approach to network development and planning adheres to the following principles:

- Primary and specialty (including behavioral health specialist) providers are supported by member-centered case management – the member, the member's family/caregiver<sup>12</sup>, along with the member's medical and behavioral health providers participate in developing and evaluating the covered services included in the member's care plan. Our member-centered case management services dovetail with the care plan to assist the member in reaching their goals(s), safely support the member in the least restrictive setting and promote the highest level of self-sufficiency.
- Provide a comprehensive care delivery network to initially meet member's needs and sustain consistency of services. The service providers are accessible and available when, where and to the degree they are needed. Our comprehensive network means that our members have access to an array of services that are at least equal to or better than community norms. Service availability and accessibility exceed AHCCCS and community standards in terms of timeliness, amount, duration, and scope.
- Our provider network is diverse and adequate to allow the member the choice to either remain in their home or to select an alternative setting in lieu of an institutional placement. Should the member require a special combination of services or service providers that are normally unavailable in the member's community, our Network Development team works cooperatively with Case Managers (CMs), PCPs and providers to reasonably meet the member's needs. This includes meeting the needs of members who have cognitive impairments, behavioral health, and other special medical needs.
- When preparing our Plan we collaborate with community stakeholders (e.g., Area Agency on Aging, Adult Protective Services, Office of the Public Fiduciary) to provide a mix of services capable of meeting a member's language and health literacy needs as well as recognizing, accommodating and being sensitive to the member's culture, race, ethnicity, and religious needs. In planning expansion or changes to our provider network, MCP works in concert with our members, members' families/caregivers and community resources so that any network change is responsive to and respectful of the needs of the member and maximizes local community-based services.

MCP recognizes the importance of work force development and accessibility of trained long term care professionals to maintain consistency for our members. Our staff has actively participated on the ALTCS Direct Care Workers Committee since its inception. As a result, MCP worked collaboratively with other AHCCCS/ALTCS providers to implement many of the positive changes to the regulations relative to Direct Care Workers (DCW). MCP has amended all Attendant Care contracts to include language requiring that all DCWs hired after January 1, 2011 meet the new training and testing standards by July 1, 2012. In the Pima and Santa Cruz GSA, Dependable Nurses, a joint venture partner of Carondelet Health Network, has received AHCCCS approval of its Direct Care Worker Training and Testing Program.

MCP currently has written agreements with a network of providers that provides all medically necessary and covered services (including PCPs, specialists, transportation, hospitals, skilled nursing facilities, ER/urgent care, home and

---

<sup>12</sup> Hereinafter, all references to "family/caregiver" include the member's guardian

community based service providers and alternative residential settings) for our ALTCS members in Maricopa County. Using these same high standards and in collaboration with community-based stakeholders we are developing and proposing a comprehensive network in the Pima and Santa Cruz GSA that exceeds AHCCCS' network requirements and will support a seamless transition of care.

MCP's provider network supports the needs of each individual member and is capable of meeting the needs of all our members. We listen to our members, members' families/caregivers, community-based stakeholders, other organizations, and our internal departments to develop, maintain and enhance our network. Network development staff maintains close communication with providers, stakeholders and community organizations, allowing us to solicit meaningful input and identify issues or opportunities for innovative arrangements. As a result, we offer several unique relationships that support the goals of providing accessibility to care; reducing avoidable emergency room visits, inpatient admissions, and re-admissions; allowing members to remain in their residential locations; collaborating with stakeholders; and improving outcomes while saving costs:

- We contract with PCPs who deliver primary care services to members in their homes or residential settings 24 hours-per-day, 7 days-per-week. We have agreements with PCPs so that this service is available in the Maricopa, Pima, and Santa Cruz GSAs.
- In the Maricopa, Pima, and Santa Cruz GSAs we developed an urgent care arrangement that offers extended hours at urgent care facilities to improve access to care.
- In light of our strong commitment to patient centered medical homes (PCMHs), MCP launched a program for our ALTCS members with St. Joseph's Family Practice Clinic in Maricopa. PCMHs are an exciting and promising approach for providing highly coordinated and responsive care to ALTCS members. MCP has identified ten additional practices in Maricopa and Pima Counties for implementation as PCMHs that we will implement during CY 2011.
- In collaboration with the Carondelet Medical Group and the University of Arizona in Pima County, we will launch a diabetes management program in CY 2011 that focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and telemonitoring for at risk members.
- Expansion of our behavioral health network and programs in the Maricopa, Pima, and Santa Cruz GSAs through collaboration with Community Partnership of Southern Arizona (CPSA). As a result of this agreement we are further expanding our behavioral health expertise and broadening services to enhance our excellent behavioral health network for ALTCS members. CPSA's Consultation and Clinical Intervention Team is an innovative approach for assessing members at high risk for placement disruption and designs services to maintain the member's current placement, if the member chooses. As the Regional Behavioral Health Authority in the Pima Region for the past 16 years, CPSA has a comprehensive service network and relationships with a vast array of providers.
- We have long-standing agreements with FQHCs in Maricopa GSA, including Adelante HealthCare, Maricopa Integrated Health System, Mountain Park Health Center, and Wesley Community Center. We also have effective agreements with FQHCs in the Pima and Santa Cruz GSA, including El Rio Health Center, Marana Health Center, Mariposa Community Health Center, Desert Senita Community Health Center, and United Community Health Center.

In designing, validating and managing our comprehensive network MCP uses GeoAccess software, the industry standard for monitoring the status of networks. It is especially valuable when comparing our network with where our members reside to determine compliance with AHCCCS accessibility and availability standards. As a result of using GeoAccess software, our capabilities include analysis of access of care standards based on a complex set of indicators including provider type, urban/rural classification, and geography. We perform GeoAccess analysis quarterly or more frequently if there are member or provider complaints – we analyze an area as small as a zip code or as large as an entire GSA. Our analysis typically includes maps showing member and provider addresses, summary information for a specific member or provider group, and comprehensive information (zip code, GSA, county or state). We routinely combine GeoAccess techniques and technologies with a host of other data and information to assist in network planning, analysis and expansion. These other data and information include but are not limited to: a) member-to-PCP ratio, b) emergent, urgent, and routine appointment availability, c) after hours audits, d) provider/member satisfaction surveys, e) analysis of provider inquiries or complaints and member grievances, f) feedback from provider site visits, g) input from other internal departments including our ALTCS case management and h) claims and encounter data. MCP continuously monitors the network to determine its effectiveness. Our goal is to analyze, review and modify our network development action plans, implement interventions, and gauge the effectiveness of those interventions.



MCP's Director of Provider Services and Director of Network Development and Contracting oversee provider monitoring and management activities. Reporting to the Chief Operating Officer (COO), these individuals and their departments work closely and cooperatively together to manage the recruitment, improve provider education, increase effective monitoring, and implement follow-up activities to meet or exceed compliance with AHCCCS network standards. Our Network Development and Contracting staff in conjunction with Provider Services staff coordinate with our Medical Management, Finance/Actuarial, ALTCS Case Management, Behavioral Health, and Member Services Departments for multi-disciplinary and cross-functional planning, innovation, design, monitoring, and management of our comprehensive network.

Our network has sufficient capacity to handle significant membership growth and was planned and executed to meet the specialized and unique needs of ALTCS members. MCP developed a supplemental provider network to minimize gaps in critical services in response to the Ball v Betlach lawsuit.

MCP offers a responsive and comprehensive network and identifies and resolves network gaps through short-term and on-going interventions. However, there are circumstances, outside of our control, that create barriers to network development. These include workforce shortages, unwillingness of providers to see AHCCCS members, and declining reimbursement rates. Despite these challenges, MCP offers creative strategies to mitigate the impact of barriers, including, but not limited to:

- Coordinating with owner facilities St. Joseph's Hospital and Medical Clinic in Maricopa County and St. Mary's Hospital in Pima County (both offer residency programs) to identify potential providers
- Collaborating with FQHCs or RHCs to expand their satellite sites
- Simplifying prior authorization requirements
- Regular communication with ALTCS case management over issues and barriers
- Increasing outreach efforts and soliciting help from current providers
- Soliciting feedback from our Member Advisory Council

Please see the following pages for a copy of the Network Development and Management Plan.



## Network Development and Management Plan



ALTCS Membership

## NETWORK MANAGEMENT PLAN

March 2011

## TABLE OF CONTENTS

INTRODUCTION .....	1
Section 2 – Evaluation of Prior Year’s Plan (CY 2010) .....	4
Section 3 – Current Network Status & Network Gaps .....	8
Section 4 – Immediate Short-Term Interventions to Address Network Gaps.....	22
Section 5 – Interventions to Fill Network Gaps .....	23
Section 6 – Outcome Measures and Evaluation of Interventions .....	28
Section 7 – Ongoing Activities for Network Management.....	29
Section 8 – Coordination Internally Between Departments.....	31
Section 9 - Coordination with External Community Agencies.....	34
Section 10 – Network Design.....	37
Section 11 – Adequacy of the Geographic Access to Tertiary Hospital Services.....	66
Section 12 – Assistance Provided to PCP’s when Referring to Specialists.....	67
Section 13 – Analysis of Appointment Availability Surveys .....	69
Section 14 – Methodologies used to Collect and Analyze Member, Provider & Staff Feedback about the Network Design & Performance... 71	
Section 15 – Listing of Non-Certified Home Health Agencies Used or Anticipate Being Used .....	75
Section 16 –Work Force Development.....	76
Section 17 – Strategies MCP uses to Provide Members with “In Home” HCBS vs. Assisted Living or Skilled Nursing Facilities .....	77
Section 18 – Alternative Residential Settings Action Plan for Contractor with 20% of their Members Residing in an Alternative Residential Setting.....	81
Section 19 – Listing of Assisted Living Facilities for which MCP has already Obtained a Waiver from the Single Choice Occupancy Requirement.....	82
Section 20 – Listing of Nursing Facilities that have Withdrawn from the Medicaid Program .....	83
Section 21 – Description of how Mercy Care Plan will handle the loss (closure, contract termination) of a major Health Care Provider (Hospital, Nursing Facility, Large Provider Group).....	84
Section 22 – Description of the Methods used to ensure that ALTCS Members receive needed services in the Event of a Natural Disaster..88	
Section 23 – Approvals.....	89

---

---

## INTRODUCTION

Mercy Care Plan (MCP) manages and maintains a comprehensive, diverse and flexible provider network for our ALTCS Members. Our Network Management Plan is designed to:

- Develop and maintain a network that promotes the values of Choice, Dignity, Independence, Individuality, Privacy, Self Determination, Member Centered Case Management, Consistency of Services, Accessibility of Network Services, and support the most integrated setting while collaborating with stakeholders.
- Meet the needs of current and future ALTCS members, including the special needs population(s), such as those members with cognitive impairments, behavioral health needs, and the aged and functionally disabled.
- Encompass a full continuum of network providers including medical and behavioral health care professionals, ancillary service providers, Home and Community-Based Service (HCBS) providers, HCBS facilities and Skilled Nursing Facilities (SNF's) to meet the requirements of the ALTCS program, and meet the complex needs of ALTCS members.
- Support and encourage member involvement in decision-making and network enhancement through our Member Advisory Council.
- Resolve ALTCS member's concerns, problems and issues timely and effectively.
- Provide the framework for coordinating and integrating medical and non-medical (behavioral health and social) services.
- Provide access to care, at least equal to or better than community norms, in terms of timeliness, amount, duration, and scope of services as those available to non-AHCCCS persons within the same service area;
- Promote home and community-based services and settings with the ability to allow ALTCS members, when appropriate, to reside in or return to their own homes versus having to reside in an institutional or alternative residential setting.
- Support those members who desire the control of their health services through Self-Directed Attendant Care (SDAC) to receive certain skilled services.
- Enhance the members' independence, well-being and safety.
- Develop services that consider the culture, race, ethnic and religious concerns of ALTCS members.
- Support the member's informal support system through respite services, adult day health care and other home and community-based services.
- Maximize the use of community based primary care services.
- Reduce utilization of unnecessary emergency room visits, one-day hospital visits, and hospital based outpatient surgeries when a lower cost surgery center is available.

- Support paraprofessional work force development in nursing facilities, alternative residential facilities, ALFs and in the home (attendant care, personal care and homemaker) to increase the number of individuals participating in the long term health care work force, and the skills of those caregivers.
- Allow providers with a variety of licenses and/or certifications that serve high-risk populations to participate in the network.
- Ensure critical activities of daily living such as bathing, toileting, dressing, feeding and transferring are met within 2 hours in the event of a gap report.
- Define HCBS services and settings that meet the needs of members who have cognitive impairments, behavioral health needs or other specialized needs.
- Implement actions/strategies to improve the quality of care to members and ensure effective and efficient utilization of health care resources.
- Identify the most significant barriers to efficient network deployment and identify opportunities to improve the quality of care delivered to members.
- Facilitate the use of sufficient numbers and types of providers for the provision of all covered services, including the provision of emergency care 24/7.
- MCP continuously monitors and enhances the provider network to support the current and future needs of our AL/TCS membership, which includes responding to expected and unexpected changes that often occur. Efforts are made to include members and their families, providers and other appropriate community organizations in the assessment and review of ongoing network strategies. Changes to the network are planned, implemented, and evaluated for continuous improvement.
- MCP monitors the timeliness and accessibility of care by providers, and ensures that covered services are available seven days per week, with emergency medical care available twenty-four hours per day, seven days per week. Because MCP has developed a network that provides timely and accessible care, critical services are provided without gaps.
- This Network Management Plan demonstrates the flexibility of our network including our capacity to serve the current and expected enrollment growth in each service area and demonstrates a stable network. The Network Management Plan addresses the following:
- Evaluation of progress made compared to the previous year's plan
- Evaluation of current network status by service type, including the network for special populations, hospital accessibility, member accessibility and the relationship between various levels of the system, including:
  - Current network status and gaps
  - Methodology for identifying current network gaps
  - Assigned responsibility & accountability for detecting and resolving network gaps
- Description of the following:
  - Short-term and ongoing interventions to fill network gaps

- Barriers to gap interventions
- Outcome measures and evaluation of interventions
- Ongoing network development and management activities
- Coordination with internal departments as well as outside entities
- Network design for general and special populations
- Geographic access to tertiary hospital services
- Assistance provided to PCPs when they refer members to specialists, including methods used to communicate the availability of this assistance to providers
- Analysis of appointment availability surveys
- Methodologies used to collect & analyze member, provider and employee feedback about the network design and performance, including the process for handling issues

The Provider Services Director (PSD) (aka Provider Services Manager) and Director of Network Development and Contracting, in conjunction with MCP's Vice President of Strategy and Business Development, reviews MCP's Plan with health plan management on a regular basis. The plan is a living document – it is designed to continually adapt to changing membership, situations, events, opportunities and concerns. We review the plan on a quarterly basis with the multi-disciplinary Strategy and Business Development Council and to make necessary adjustments and improvements to our network.

The plan is based on our management goals. Network management, stabilization and ease of plan processes are part of our management goals to:

- Maintain a flexible network to meet the members' specialized needs and maintain members in the least restrictive setting
- Continually improve accessibility and availability of care and services
- Reduce unnecessary emergency room utilization
- Eliminate medically unnecessary hospital utilization while ensuring steps taken are in the best interest of the member's healthcare outcome
- Lay the ground work for introduction of Health Information Exchange
- Encourage the use of electronic claim submission, electronic fund transfer and electronic remittance advice.

## SECTION 2 – EVALUATION OF PRIOR YEAR’S PLAN (CY 2010)

### ACCOMPLISHMENTS FOR CONTRACT YEAR 2010 (CY2010)

Contract Year 2010 was identified as “**The Year of the Member**” at MCP. The entire MCP organization rallied to better understand and encourage stronger communication and relationship building with members.

Our accomplishments during this period included:

- MCP executives’ shadowed ALTCS Case Managers (CMs) on home visits to learn firsthand the challenges and success stories our members have navigating the health care system. These stories were featured in the AetNet Medicaid Business Unit newsletters on a monthly basis throughout the year. These visits allowed the MCP’s executive team to witness the role of the case manager (CM) and the complexities of managing all of the components that go into conducting a full member assessment for a member residing in their own home or other residential setting.
- MCP holds quarterly Member Advisory Council (MAC) meetings to obtain member input on materials, programs and health plan processes. The objective of the MAC is to provide a forum for two-way communication between MCP and its members. The MAC is comprised entirely of AHCCCS recipients; membership is split evenly between acute (6) and ALTCS (6) members. The MCP MAC serves as a forum for members’ input on quality service improvement strategies and overall effectiveness of operations.
- MCP invited two of the MAC members to share their story at an all-employee meeting. It helped staff at all levels to understand how their jobs directly impact members on a daily basis. This open line of communication is consistent with MCP’s values and is strongly encouraged at all levels. MCP’s 2010 cultural competency/health literacy plan focused on building a culturally competent and health literate healthcare delivery system. MCP sponsored a Cultural Competency and Health Literacy Conference inviting providers, AHCCCS health plans and AHCCCS staff. The meeting objectives included:
  - Understanding the relationship between trust and cultural differences and health literacy
  - Identifying ways to build health literacy/cultural competency into our current processes and systems: training, communication, outreach, provider education and motivational interviewing
- In CY2010 MCP identified the need to improve member satisfaction with transportation services. As a result, MCP developed a special, proprietary tracking and reporting software program to allow for fast, on-line documentation of transportation requests and issues. This electronic tool saves time and reduces staffing costs since transportation requests are sent electronically instead of by facsimile machine. MCP also contracted with an additional taxi transportation provider resulting in great member choice among transport providers. This competition helped to motivate transportation providers to improve service and response time. These interventions resulted in a seven percent reduction in transportation complaints.
- MCP has had a focused effort to improve electronic claims submission and payment. As of February 2011, current claims received electronically is 70.4 percent, which exceeds the AHCCCS requirement.

- As of February 2011, providers receiving funds electronically is 65.3 percent.
- In CY 2010, MCP began design and rebuild of the member and provider website. The website will launch in Contract Year 2011 (CY2011). The new website distinctly separates each line of business – acute, ALTCS and our Medicare Advantage SNP programs. This separation offers providers a better reference point when seeking assistance about our network, member benefit coverage and authorization requirements. These modifications are expected to improve ease of navigation, efficiency and effectiveness. The new website gives providers on-line access to:
  - Medical management guidelines
  - Timely announcements regarding policy changes, meeting notices, regulatory updates, etc.
  - A resource library for all providers. The library contains downloadable policies and procedures, fee schedules and other forms for provider office ease and use.
  - A mechanism to ID Provider contacts within the health plan. Because MCP has provider services representatives (PSR) assigned by specialty, hospital delivery system or practice type, we have created a “Find Your Provider Rep” section that assists the provider in identifying their specially trained PSR, their contact phone numbers (both office and cell) and an e-mail address.
  - A secure provider web portal that provides a platform for MCP to communicate health care benefit information directly to providers. Users can perform transactions, download information and work interactively with member health care benefit information. For example, the provider can:
    - Manage administrative tasks which permit the user to make name, password, e-mail, address and security question changes
    - Enroll in MCP's EFT program
    - Send secure messages to MCP
    - View member, provider, claim, authorization, remit and panel roster information
    - Verify current eligibility on one or more members
    - Search for providers by name, geographic location, specialty type, etc. Members can get details for and directions to a provider office
    - Obtain claim status by member, provider, claim number or service dates
    - Search for provider claim payment information by check number, provider, claim number of check issue/service dates
    - Search for provider authorizations by member, provider, authorization data or submission/service dates
    - Submit an authorization request on-line. Three types of authorization types are available: medical inpatient, outpatient and DME rental.
    - Search for fee schedule information by CPT code

- MCP created a weekly, internal communication that provides details related to any updates to the network (additional providers, new provider locations, regulatory and/or process updates). These updates are shared with internal departments who may have regular contact with our provider community such as the prior authorization, claims, medical management and member services staff. The updates have greatly improved our internal communications and have resulted in improved provider satisfaction.
- MCP implemented a new provider communication method by adding messages to the end of provider remits. This proven communication method is timely, is received by the most appropriate audience and can be issued on a regular, on-going basis much more cost-effectively than regular mail. This method of communication was used to share updates related to our changes in Laboratory and Radiology vendors and resulted in a much smoother transition.
- Our Provider Services Team was restructured to improve timeliness, efficiency and effectiveness of our customer service activities. This team, lead by a director with over 15 years of experience, is highly skilled and specialized. Provider Services staffing levels are regularly evaluated to confirm that service levels are maintained and adjustments are made whenever necessary. Job descriptions were re-written to enhance MCPs ability to promptly meet the needs of the provider population. In our efforts to ensure easy, effective and efficient access to all providers needing assistance, we have assigned program and specialty specific provider services representatives. For example, provider services representatives assigned to specialties such as Behavioral Health, SNF, HCBS and Hospice services have extensive professional knowledge gained from work experience in these industries. The provider services representative assigned to the Assisted Living Facilities works closely with the Foundation for Senior Living for adult foster care services, and has built a strong relationship with the Arizona Health Care Association (AHCA), which allows the provider services representative up-to-date knowledge on current and upcoming changes in assisted living. Our full-time claim educator has over 20 years of healthcare experience and is a certified coder.
- MCP has four distinct specialized provider focused teams. These teams work collaboratively to address the needs of our provider community:
  - **Ancillary Team** – Assigned to Ambulatory Surgery Centers, Laboratory, DME, Radiology and Urgent Care Facilities.
  - **Hospital/Federally Qualified Health Center (FQHC) Team** – Assigned to hospital delivery systems, FQHCs and large, multi-specialty practices
  - **Primary/Specialty Physician Team** – Assigned to PCPs and specialty physicians.
  - **ALTCS/MCA Team** – Assigned to specific, specialty providers such as Skilled Nursing Facilities, HCBS providers, behavioral health providers and Assisted Living Centers/Homes.
- Each team member is responsible for improving Provider satisfaction. Provider satisfaction is a measurable goal and is included in each employee's bi-annual report card. Provider Services will launch new evaluation methods in CY2011. A provider feedback postcard entitled – “*What Can I Do for You?*” will allow providers to forward comments about their most recent experience with the provider services representative, including an opportunity to add suggestions for improvements in operations, communications, responsiveness and staff training. The postcard will come directly to the Provider Services Director and suggestions will be promptly responded to. MCP will utilize this information to make process improvements to our operations, strengthened provider services representative training and augmentations to our staffing levels if need be.

- MCP provider manuals meet all of the required criteria defined by AHCCCS/ALTCS policies and are continuously updated and posted as on-line reference tools. Due to the uniqueness of each line of business, MCP created three distinctly written provider manuals, one each for the Acute, ALTCS and the Medicare Advantage Special Needs programs. The manuals offer a better definition of each program, requirements for prior authorization and referrals, regulatory requirements, benefit differences and networks. Updates to the manuals are made on a real-time basis as changes in regulations occur, procedures in the Plan change, etc.
- MCP updated provider-related documents (e.g. provider manual, provider contracts, provider-related policies, provider training materials and provider communication) to validate compliance with the ALTCS CY2011 contract terms.
- On a regular basis, MCP managers and supervisors from Provider Services, Claims, Encounters, Appeals and CICR departments meet to review provider complaints and claims disputes. This workgroup has been effective in reducing the number of claim related phone calls, identifying root cause of any issues and recommending timely changes which has improved the overall communication among departments. Additionally, the number of overall grievances submitted by providers for claim-related issues has significantly decreased from CY2009 to CY2010. These process improvement actions are just some of the changes that have helped to decrease the volume of provider complaints that were previously received directly by AHCCCS.

### SECTION 3 – CURRENT NETWORK STATUS & NETWORK GAPS

---

Mercy Care Plan (MCP) was one of the first AHCCCS-contracted health plans and now serves acute, long term care, Health Care Group, and Developmentally Disabled members. We also serve Arizonans who are eligible for both Medicare and AHCCCS through Mercy Care Advantage (MCA). MCA is a unique type of Medicare Advantage Plan that is also a Medicare Special Needs Plan, or SNP. CMS regulates MCA and requires a comprehensive network of providers in Maricopa, Pima and Santa Cruz counties. In each of these programs MCP successfully develops, manages and directs a complete, responsive, quality and member-driven network of primary and specialty care providers, behavioral health services, hospitals, ancillary providers and other providers to serve each member, including our ALTCS members. We apply this distinctive experience to our ALTCS Network Development and Management Plan (Plan). MCP, through its dedicated local hospital owners and highly qualified staff, is in an excellent position to address the specialized needs of ALTCS members in the Maricopa, Pima and Santa Cruz Geographic Service Areas (GSAs) and demonstrates our capacity to serve the current and expected enrollment growth in each service area. Our network meets AHCCCS' requirements and specifications and demonstrates how we provide each member a choice of providers, accessibility and availability of services, resulting from our collaboration with members, providers and community agencies.

MCP coordinates, manages, directs and provides acute care, long term care, behavioral health and case management services to each ALTCS member regardless of their residence, special health care or chronic care needs. Our approach to network development and planning adheres to the following principles:

- Provide a comprehensive care delivery network to initially meet and sustain consistency of services. Our network links with the member's support system, including caregivers, community stakeholders and others.
- Our comprehensive network means that our members have access to an array of services that are at least equal to or better than community norms. Service availability and accessibility exceeds AHCCCS and community standards in terms of timeliness, amount, duration and scope.
- Our provider network is appropriate and adequate to allow the member the choice either to remain in their home or to select an alternative setting in lieu of an institutional placement. Should the member require a special combination of services or service providers that are normally unavailable in the member's community, the network development team works collaboratively with the case management team, PCP and providers to reasonably meet the member's needs. This includes, meeting the needs of members who have cognitive impairments, behavioral health, and other special medical needs.
- When preparing our network development plan we collaborate with community stakeholders (e.g., Area Agency on Aging, Adult Protective Services, Office of the Public Fiduciary) to provide a mix of services capable of meeting a member's language and health literacy needs as well as recognizing, accommodating and being sensitive to the member's culture, race ethnicity, and religious needs.
- In planning for expansion or changes to our provider network, MCP works in concert with our members, members' families/caregivers and community resources so that any network change is responsive to and respectful of the needs of the member and maximizes local community-based services.

MCP currently has written agreements with a network that provides all medically necessary and covered services (including PCPs, specialists, transportation, hospitals, skilled nursing facilities, ER/urgent care, home and community based service providers and alternative residential settings) for our ALTCS members in Maricopa County. Using these same high standards and in collaboration with community-based stakeholders we have developed a comprehensive ALTCS network in Pima and Santa Cruz GSA that exceeds AHCCCS' network requirements and will support a seamless transition of care.

MCP's provider network supports the needs of each individual member and is capable of meeting the needs of all our members. We listen to our members, members' families/caregivers, community-based stakeholders, other organizations and our internal departments to develop, maintain and enhance our network. Network development staff maintains close communication with providers, stakeholders and community organizations, allowing us to solicit meaningful input and identify issues or opportunities for innovative arrangements. As a result, we offer several unique relationships that support the goals of providing accessibility to care; reducing avoidable emergency room visits, inpatient admissions and re-admissions; allowing members to remain in their residential locations; collaborating with stakeholders; and improving outcomes while saving costs:

- Contracts with PCPs that offer primary care to members in their homes or other residential settings 24 hours-per-day, 7 days-per-week. We have agreements with PCPs so that this service will be available in the Maricopa, Pima and Santa Cruz GSAs.
- In the Maricopa, Pima and Santa Cruz GSAs, we have developed an urgent care network that offers specialized, focused urgent care services for improved access to after-hours care.
- Because of our strong commitment to the patient centered medical home (PCMH) concept, MCP has launched a PCMH program for our ALTCS members assigned to the St. Joseph's Family Practice Clinic in Maricopa County – patient centered medical homes are an exciting and promising approach for providing highly coordinated and responsive care to ALTCS members. MCP has identified ten additional practices in Maricopa and Pima Counties for implementation during CY2011.
- In collaboration with the Carondelet Medical Group and the University of Arizona in Pima County, we will launch a diabetes management program in CY2011 that focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and tele-monitoring technology for at risk members.
- Expansion of our behavioral health network and programs in Maricopa, Pima and Santa Cruz GSAs through collaboration with Community Partnership of Southern Arizona (CPSA). As a result of this agreement we are further expanding our behavioral health expertise and broadening services to enhance our excellent behavioral health network for ALTCS members. CPSA's Consultation and Clinical Intervention Team is an innovative approach for assessing members at high risk for placement disruption and designs services to meet members' specialized needs.
- Improving services to homeless members in the Pima and Santa Cruz GSA through the Southern Arizona Health Village for the Homeless Van of Hope community partnership. This program provides mobile medical services at sites frequented by homeless members.
- We have long-standing agreements with FQHCs in Maricopa GSA, including Adelante HealthCare, Maricopa Integrated Health System, Mountain Park Health Center and Wesley Community Center. We also have effective agreements with FQHCs in Pima and Santa Cruz GSA, including El Rio Health Center, Marana Health Center, Mariposa Community Health Center, Desert Senita Community Health Center and United Community Health Center.

### ***Methodology Used to Assess Network Status & Identify Gaps***

MCP has an in-depth process to monitor the status of the network, project future needs and readily identify any network gaps. We regularly review:

- GeoAccess analysis data of our network using both AHCCCS network adequacy standards and/or other industry standards.
- Member-to-primary care physician (PCP) ratio that takes into account PCP capacity and panel status. We generate reports to measure capacity by line of business for each PCP by GSA. MCP utilizes internal reports and proven processes to validate PCP panel size and actively monitors PCP panel to assess member access to care. When a provider fails to meet member accessibility standards, MCP imposes a corrective action plan, including up to closing the provider's panel.
- Member-to-specialist ratio for critical specialties in urban GSA's such as GSA 50 (Pima and Santa Cruz) and GSA 52 (Maricopa).
- Accessibility standards such as appointment availability, wait times in the office, and after-hours accessibility which are monitored regularly throughout the year.
- Number of physicians who have privileges at and practices in hospitals and the adequacy of specialist coverage at each contracted hospital.
- Our member population in terms of: future needs based upon membership growth, expected utilization of services and characteristics of the population such as special health care needs
- Member grievances and provider complaints to identify areas where member and provider education may be beneficial.
- Member and provider annual satisfaction survey data to identify opportunities for network enhancements and operational improvements.
- Services provided by out-of-network providers to validate network adequacy or expansion needs.
- Ambulatory Medical Record Reviews (AMRR) that measure providers' compliance with AHCCCS and MCP medical record standards.
- Credentialing and re-credentialing processes which promptly verify provider qualifications that meet MCP standards.
- Ratio of members residing in their own homes vs. those in other types of placements (i.e., SNFs or Alternative Residential Settings) to ensure placement effectiveness.
- Ongoing review of special network indicators including but not limited to: the number and type of out of area placements, the number and types of member grievances and provider claim disputes, listing of nursing facilities that have withdrawn from AHCCCS but are in the MCP network, listing of ALFs that have obtained a waiver from the Single Choice Occupancy requirement, and transportation reports that monitor member satisfaction and response time.
- Review of the CMS Arizona Opt-Out Provider Listing to validate that the provider has not opted out of participation in Medicare or AHCCCS or is excluded from participating in federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

- Notification to individual providers and/or provider groups in a timely manner of MCP's decision to decline their request for participation in MCP's network.

MCP also solicits input on current and future network needs from:

**Internal MCP Departments.** Input from staff actively involved in working with members and the provider community is critical in terms of providing up-to-date information about network issues; this includes but is not limited to: staff from LTC Case Management, Health Plan Operations, Member Services, Provider Services, Quality Management/Utilization Management, Medical Management, Grievance, Pharmacy, Behavioral Health and Claims departments. MCP has developed workgroups which include managers, directors and staff from multiple departments who review real-time data and resolve issues. These workgroups also review data trended over time to identify provider-specific or network-wide patterns to escalate to senior management and formal committees for further direction. MCP has dedicated workgroups that focus on topics such as member grievances; member appeals and claims disputes; operational topics such as contract configuration, provider data and claims research; and long term care network needs specific to ALTCS members. MCP also has developed formal committees to manage the network. Key MCP committees that are involved with managing the network include the Quality Management/Utilization Management Committee (QM/UM Committee), Peer Review Committee, Credentialing Committee, Pharmacy and Therapeutics Committee, and the Strategy and Business Development Council.

**Providers and Members.** Feedback is obtained through a variety of methods, including but not limited to: 1) member and provider satisfaction surveys, (2) complaints, grievances and appeals, (3) members and providers participating on formal and informal ad hoc health plan committees, including the Long Term Care Provider/Member Council, and (4) meetings with and telephone calls from providers and/or members.

MCP compares our survey and monitoring results against AHCCCS/ALTCS network adequacy standards. In instances where there is no AHCCCS/ALTCS specified standard, we compare our network to community standards and our performance trends over time to gauge network adequacy. We also review results from county to county to determine if identified concerns apply to the overall network or are limited to specific providers or in specific geographic areas of service.

In addition, our PSD is responsible for: 1) accounting for each Provider Inquiry Concern or Request for Information (PICRI) received and making sure the provider receives an accurate, complete, and timely response, 2) trending this information to determine a pattern, and 3) communicating trends within the MCP organization. The PSD reviews both daily and weekly call tracking reports to identify and determine the progress of resolving outstanding PICRI, the accuracy of closed PICRI and monitors overall performance. Our PSD uses these reports to assist Provider Services Representatives (PSR) in closing PICRI, identifying individual provider training needs and tracking and trending issues to determine if any operational areas need improvement. Results of tracking and trending are used to:

- Assess network status and identify potential network gaps in service
- Identify individual and systemic provider issues to determine opportunities to improve processes
- Develop and monitor performance improvement projects
- Identify and refer member service issues to our member services department for resolution
- Detect and refer potential fraud and abuse to our compliance department

- Determine if provider training needs adjustment or enhancement
- Determine if MCP training needs to be improved
- Identify requests for termination due to rates and reports these quarterly to AHCCCS.

Our PSD meets with senior managers from other MCP departments including, but not limited to, member services, health plan operations, case management, prior authorization, medical management (utilization or quality management), to discuss PICRI, receive input, determine next best steps and identify potential network gaps. PSD reports PICRI trends and identified improvement initiatives to the QM/UM Committee. The QM/UM Committee reviews PICRI trends, approves recommended intervention activities, identifies additional performance improvement activities, assigns action plans, and monitors the action plans to completion. The QM/UM Committee also utilizes these results to make recommendations regarding the quality and appropriateness of care provided by our network providers to our members, improvement opportunities for provider and employee training, operational improvements, or policy changes. Quality of care tracking and trending results are reported to AHCCCS on a quarterly basis through the use of the Quarterly Quality Management Report.

Using our continuous process improvement strategy, Plan Do Study Act (PDSA), the results of our tracking and trending of PICRI are analyzed to determine if enhancements to our processes for network modification, training personnel, receiving or responding to PICRI. MCP has dedicated substantial resources to the PICRI process to receive, monitor and accurately, completely and timely respond to PICRI. We have seen strong evidence that this approach aids in the identification of provider's issues and concerns. As a result we have been able to avoid misunderstandings that may result in unnecessary loss of providers, disruption in care, reduced quality, and increased costs. Our robust process recognizes the importance of PICRI in improving our programs, operations, training, and provider services.

The following benchmarks are used to gauge the adequacy of the network:

**Urban GSA's (Maricopa and Pima County):**

- 95 percent of members within the Metropolitan areas of Phoenix and Tucson have access to at least one PCP, dentist and pharmacy within 5 miles of their home zip code
- Members outside these metro areas have access within a 10 mile radius to at least one PCP and pharmacy
- A mix of providers, including primary care providers, with appropriate coverage for our member population, specific ages and genders and lines of business
- A minimum of one dentist to 1,000 members
- Specialist coverage at each contracted hospital for all major specialties
- At least one contracted hospital within each of the service districts
- Sufficient personnel for the provision of covered services, including emergency medical care on a 24-hour per day, 7 days per week schedule
- Monitoring of split zip codes to confirm that members residing in bordering communities have easy access to care

- At least one OB, family planning and pediatric specialty is available to members in any service area where a PCP does not offer these services
- Appropriate availability of countywide coverage of HCBS services including Adult Day Health Centers, attendant care, emergency alert, home modifications, habilitation, home health care, home delivered meals, homemaker, hospice, personal care and respite care are available in each GSA. MCP certifies that each home and community based service provider offers seven day a week, 24-hour coverage as dictated by the needs of the member.
- Adequate coverage for Behavioral Health Services are available to include Behavioral Management, Inpatient services, Emergency Care, Evaluation, Individual Group and Family Counseling Options, Medication Monitoring, Behavioral Day Health Programs/Partial Care and Psychosocial Rehabilitation to meet the specific needs of our members
- Adequate numbers of Skilled Nursing Facilities, Assisted Living Homes, Assisted Living Homes, DD Group Homes, Adult Foster Care homes, and residential locations for behavioral health placements such as group homes, are available to meet the needs of the members and offer geographic choice
- Geographic accessibility of ancillary service providers such as DME, laboratory patient service centers, medical imaging locations and various types of therapy providers that meet the needs of our members.
- Reports that document timely and responsive transportation services

### **Responsibilities for Identifying Network Enhancements/Gaps**

The Directors of Network Development & Contracting and PSD oversee the monitoring and management activities related to the provider network. These departments collaborate to manage the recruitment, education, monitoring, and follow-up activities necessary to meet or exceed compliance with AHCCCS network standards and to identify any network enhancements or gaps. Other departments (such as quality management, medical management, utilization management, case management, member services, grievance and the claims department) participate in the process to identify network enhancements or gaps.

Through the development of a Network Strategy and Business Development Council, MCP is evaluating network need on a specialty-by-specialty basis. The priorities are primarily driven by several factors:

1. Member defined needs
2. Claim and payment volume
3. Appeal volume – identification of issues revolving around a particular specialty, service or provider group
4. Claim audit – identification of issues revolving around a particular specialty, service or provider group
5. Provider “noise” about fee schedules or claim errors
6. Encounter issues
7. Interdepartmental Requests – these may be routed by Medical Management staff, Medical Directors, QM or by Member Services when particular issues of concern arise.
8. Concerns regarding the quality of care

The Plan utilizes a strategic approach to address enhancements, compression or other recommendations to update the provider network. Each proposed update to the network undergoes a full and comprehensive business planning process to define the network need, provider participation requirements and reimbursement recommendations, claim and encounter payment system requirements and includes a full project implementation plan. During the implementation of these network strategy projects, MCP expects to streamline its network to a more manageable size. This allows the plan to not only meet its regulatory requirements for provider visits and education, but also to better manage the quality, reimbursement and engagement of providers in its network.

In 2010, MCP established key alliances with large health care providers. Sonora Quest Laboratories (SQL) became our exclusive provider for laboratory services. This change offered our members better access to a number of patient service centers available throughout Arizona, while reducing the cost of laboratory services. Nationwide Vision was introduced as the exclusive vision vendor bringing an expansive network of optometrists and geographically located service centers. With this arrangement, MCP was able to offer vision screening and testing to our members in SNF and residential settings. A re-contracted radiology network was implemented resulting in cost savings to the Plan. These efficiencies have allowed MCP to improve the efficiency of the Medicaid Program resources.

### **Current Network Status and Network Gaps for Maricopa, Pima and Santa Cruz Counties**

MCP is well prepared to meet the needs of the ALTCS members in Pima and Santa Cruz Counties. Our current AHCCCS Acute Care network already includes providers of all specialty types, including PCPS, specialists, dentists and ancillary service providers. MCP has added additional practitioners who will provide primary care services to our members in their residential setting, including SNFs, ALFs and member homes. We have built, through written agreements, a long term care network similar to that of the current incumbent plan which exceeds all of the required Network Standards prescribed by AHCCCS/ALTCS. The network has sufficient capacity to accommodate membership growth. This network is also more than sufficient to handle projected growth in the SNF, AFC, ALH, ALC, HCBS and Behavioral Health areas. Great efforts were made in securing this network, so that MCP could maintain the placements of the current ALTCS membership in the Pima and Santa Cruz GSA's. MCP monitors the network regularly to identify areas where members and/or the network may benefit from additional providers so that member's have a wide choice of services.

In Maricopa County, our solid network of providers already includes providers across all specialty types, including primary care, specialty physicians, dentists and ancillary providers. The Maricopa Acute and LTC networks have already proven to be sufficient to meet the needs of our members while offering choice, and are such that we can handle significant growth.

MCP takes advantage of an array of opportunities to evaluate the status of the current network for gaps on an ongoing basis. An evaluation of these methodologies along with efforts taken to fill any identified gaps is identified below:

### **GSA 50 – PIMA and SANTA CRUZ COUNTY**

MCP exceeds all network standards in this GSA and providers have reached a 100% compliance standard on our accessibility measurements, based on the RFP requirements. MCP offers Mercy Care Advantage (MCA); a special needs plan to members residing in Pima County. The MCA program is a convenient option for our dually-eligible members to receive all covered Medicare and Medicaid services through a single coordinated plan and eases the burden of the provider by allowing a single billing entity.

Below is a summary of the current network status:

**Hospitals:** MCP exceeds the AHCCCS standard for hospitals in all districts. MCP contracts with nine hospitals in Pima County and one in Santa Cruz County. Existing contracts with admitting physicians provide members with adequate access to all primary care and specialty care.

**PCP's:** The network meets or exceeds the AHCCCS standard that 95% of members residing within metropolitan Tucson do not have to travel more than 5 miles to visit a PCP. MCP's PCP Network includes internists, family practitioners, pediatricians, OB/GYNs, certified nurse midwives, nurse practitioners and physician assistants. MCP maintains contracts with every FQHC including El Rio Santa Cruz Neighborhood Health Care Center, Marana Community Health Center, and United Community Health Care Center in Pima County and Mariposa Health Care Center in Santa Cruz County. MCP contracts with Desert Senita in Ajo, Arizona. MCP also contracts with St. Elizabeth, an FQHC like facility which is jointly sponsored by Catholic Community Services of Southern Arizona and our sponsor organization, the Carondelet Health Network. The MCP PCP network in Pima/Santa Cruz County is prepared to accommodate 4,300 new members should the ALTCS business be awarded to us in Pima/Santa Cruz GSA.

MCP's network of PCP's includes providers with a sub-specialty of geriatrics. When appropriate, elderly ALTCS members are assigned to a PCP specializing in geriatric medicine who will concentrate on the physical and emotional limitations common in older adults, including such problems as falls, incontinence, osteoporosis, memory and behavioral disorders and nutrition. PCPs and nurse practitioners are also assigned to provide services within the SNF, keeping member transportation to a minimum and increasing member satisfaction and care coordination.

**Specialists:** MCP maintains contracts with a wide array of specialists throughout Pima and Santa Cruz County and is designed to meet the specialized needs of MCP members. This includes all provider specialties as required in the AHCCCS/ALTCS program.

**Ancillary Services:** The ancillary network is robust, with an abundance of providers across all provider types, including Sonora Quest Laboratories, NextCare Urgent Care, Dependable Home Health and DME, Option 1 for enteral nutrition therapies and Nationwide Vision for vision testing and eyewear. MCP contracts with multiple mobile laboratory and radiology providers to perform services in SNFs and assisted living facilities, in addition to our lab and radiology facilities. Our exclusive vision care provider, Nationwide Vision, offers on-site vision care and screening services to members residing in skilled nursing facilities. In Santa Cruz County, laboratory and radiology services are provided by Holy Cross Hospital. MCP's ancillary network also includes therapy providers in acute settings as well as SNFs and the home.

**Oral Health:** MCP maintains a dental director and a dental network to provide covered dental services to eligible members. This includes a mobile dentistry program that provides services in skilled nursing facilities and our more rural locations.

**Pharmacy:** Express Scripts, Inc. (ESI) under MCP's management and oversight, administers our pharmacy network. Analysis of GeoAccess reports show that, MCP exceeds the AHCCCS standard of access to a pharmacy within a five-mile radius of

where the member resides. To accommodate members who may live outside of the five-mile radius, we offer transportation services to the nearest pharmacy. MCP also offers mail order pharmacy services through our PBM to members who might prefer this service.

MCP contracts with pharmacy providers who offer services to non-dual members living in skilled nursing facilities and assisted living facilities. The use of a pharmacy provider specializing in institutional services results in higher quality, more cost effective services being provided to our ALTCS membership. These pharmacy options far exceed the ALTCS requirements.

**Transportation:** We contract with a variety of countywide transportation providers, including emergency and non-emergency ambulance providers, wheelchair and stretcher vans, as well as taxicab services to ensure members arrive at their scheduled appointments on time, but no sooner than one hour before or wait more than one hour after the conclusion of the treatment. The appropriate mode of transportation is provided based on the specific needs of the member.

**Hospice:** MCP contracts with several hospice providers including Carondelet Hospice and Palliative Care, a Medicare-certified Hospice that serves adults, children and infants with a limited life expectancy. Carondelet serves patients and their families in the greater Tucson area, Green Valley, and Santa Cruz County with teams of physicians, registered nurses, social workers, chaplains, counselors, home health aides and volunteers. When a member is in hospice in a SNF, MCP reimburses the SNF at 100% of the class specific SNF rate. MCP does not provide ALTCS services which are duplicative of the services included in the hospice benefit, unless the hospice agency is unable to provide for covered medically necessary services. MCP does not consider attendant care service duplicative of Hospice services.

### **Long Term Care Services – Institutional:**

**Skilled Nursing Facilities:** MCP meets AHCCCS' network standards for nursing facilities in all zones. Our nursing facility network is dispersed geographically, providing access to the ALTCS membership countywide. There are sufficient skilled nursing facilities in the contracted network to meet the needs of the ALTCS population (e.g. members who are ventilator dependent or who have behavioral health conditions) via contracts with Posada del Sol, Devon Gables and Santa Rosa as these facilities have specialized programs for these members with complex needs. MCP's network development and contracts team actively pursues contracting opportunities as new member needs are identified and facilities are opened. MCP will collaborate with providers to develop additional placement options whenever appropriate.

### **HCBS & Alternative Residential Settings**

MCP's network meets all the requirements for the Pima and Santa Cruz GSA for Adult Foster Care homes. MCP meets AHCCCS' network standards for alternative residential settings and for the projected increase in membership and utilization of services. This network will more than adequately serve the current ALTCS member population in Pima County.

**Foster Care Homes:**

The MCP network includes AFC homes, which exceeds the AHCCCS requirements.

**Assisted Living Homes:**

MCP exceeds the AHCCCS required network standards for assisted living homes in all zones.

**Assisted Living Centers:**

MCP exceeds the AHCCCS network standards for Assisted Living Centers. Currently, the network does not include any assisted living facility for which MCP has obtained a waiver from the Single Choice Occupancy Requirement.

**HCBS:**

MCP's network of home and community-based services meets the AHCCCS network standards to include Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite. LTC Case Management continuously monitors a "non-provision of service log" that providers complete should a non-provision of service occur. If a non-provision of service does occur, MCP takes immediate action to resolve the gap and the AL/TCS team evaluates the situation and if appropriate, makes a recommendation for network adjustments. MCP contracts with Pima Council on Aging and the Santa Cruz County Area Agency on Aging – Seniors Council to provide HCBS Services, in addition to several community providers.

**Spouse and Self-Directed  
Attendant Care Services:**

MCP continues to support Spouse and Self-Directed Attendant Care services.

**Behavioral Health Services:**

MCPs worked collaboratively with the Regional Behavioral Health Authority (RBHA), Community Partnership of Southern Arizona (CPSA). This partnership has allowed MCP, through written agreements, develop a robust, countywide, behavioral health network which exceeds the AHCCCS' network standards (with the exception of TBI homes, which are not available in Pima or Santa Cruz County). This robust network been developed over the years through a comprehensive process including tracking member enrollment, eligibility, penetration rates and anticipated growth of member populations; input of members/member families and other stakeholders across the Region; and, trending of service data for sufficiency.

This collaborative behavioral health network is more than adequate to meet current and future needs for the AL/TCS membership. MCP provides behavioral health services in both institutional, and home and community-based settings. The behavioral health delivery system includes behavioral management providers, behavioral health Level 1 providers, institution for mental disease, inpatient psychiatric residential facilities, partial hospital programs, individual and group counseling, psychosocial rehabilitation, intensive outpatient programs and nursing facilities. Add to this our array of home and community-based providers, which offer a full spectrum of alternative residential settings that include:

- Behavioral Management
- Inpatient Services

- Emergency Care
- Evaluation
- Individual, Group and Family Counseling,
- Medication Monitoring
- Behavioral Health Day Programs/Partial Care
- Psychosocial Rehabilitation
- Adult Foster Care Homes with 24 hour awake staff
- Therapeutic Foster Care Homes
- Alzheimer's Treatment Facilities
- Assisted Living Facilities
- Behavioral Health Level II Group Homes
- Behavioral Health Level III Group
- Child Development Foster Care Homes
- Group Homes
- Substance Abuse Treatment Centers
- Alternative Residential Settings (including specialized apartment settings) and,
- Habilitation providers

**GSA 52 – MARICOPA COUNTY**

MCP exceeds all network standards in this GSA and providers have reached a 99 percent compliance standard on our accessibility measurements conducted in CY2010. MCP offers Mercy Care Advantage (MCA); a special needs plan to members residing in Maricopa County. The MCA program is a convenient option for our dually-eligible members to receive all covered Medicare and Medicaid services through a single plan.

Below is a summary of the current network status:

- Hospitals:** MCP exceeds the AHCCCS standard for hospitals in Metropolitan Phoenix and Wickenburg. MCP contracts with 40 hospitals in the Phoenix-metropolitan area. Our hospital network currently includes all Catholic Healthcare West, Banner Health, John C. Lincoln, Abrazo, IASIS, Maricopa Medical Center and Scottsdale Healthcare entities. MCP contracts with admitting physicians provide members with adequate access to all primary care and specialty care services.
- PCP's:** The network meets or exceeds the AHCCCS standard that 95% of members residing within metropolitan Phoenix do not have to travel more than five miles to visit a PCP. Our PCP network includes internists, family practitioners, pediatricians, OB/GYNs, certified nurse midwives, nurse practitioners and physician assistants. MCP maintains contracts with every FQHC including John C. Lincoln Community Health Center, Maricopa County Health Care for the Homeless, Maricopa Integrated Health System, Mountain Park Health Center, Wesley Community Center and

Adelante Healthcare. Although we do not have providers in the community of Youngtown, our members do not have to travel more than five miles to access services. We are actively pursuing contracts with all available providers in the Youngtown community.

MCP's network of PCP's includes providers with a sub-specialty of geriatrics. When appropriate, elderly ALTCS members are assigned to a PCP specializing in geriatric medicine who will concentrate on the physical and emotional limitations common in older adults, including such problems as falls, incontinence, osteoporosis, memory and behavioral disorders and nutrition. PCPs and nurse practitioners are also assigned to provide services within the SNF, keeping member transportation to a minimum.

**Specialists:** MCP maintains contracts with a wide array of specialists throughout Maricopa County designed to meet the specialized needs of MCP members. This includes all provider specialties as required in the AHCCCS/ALTCS program.

**Ancillary Services:** The ancillary network is robust, with an abundance of providers across most provider types, including urgent care, home health and infusion, various therapy (PT, OT and ST providers) DME, vision care, transportation, laboratory and hospice services. MCP contracts with mobile laboratory and radiology (medical imaging) providers for services in assisted living centers. Our exclusive vision care provider, Nationwide Vision, offers on-site vision care and screening services to members residing in a skilled nursing facility.

**Oral Health:** MCP maintains a dental director and a dental network to provide covered dental services to eligible members. This includes a mobile dentistry service that provides dental care in skilled nursing facilities.

**Pharmacy:** Express Scripts, Inc. (ESI), under MCP's management and direction, administers our pharmacy network. Analysis of GeoAccess reports show that, MCP exceeds the AHCCCS standard of access to a pharmacy within a five-mile radius of where the member resides. To accommodate members who may live outside of the five-mile radius, we offer transportation services to the nearest pharmacy. MCP also offers mail order pharmacy services through our PBM to members who might prefer this service.

MCP contracts with pharmacy providers who offer services to non-dual members living in skilled nursing facilities and assisted living facilities. The use of a pharmacy provider specializing in institutional services results in higher quality, more cost effective services being provided to our ALTCS membership.

**Transportation:** We contract with a variety of transportation providers, including emergency and non-emergency ambulance providers, wheelchair and stretcher vans, as well as taxicab services.

### **Long Term Care Services – Institutional**

**Skilled Nursing Facilities:** MCP meets AHCCCS' network standards for nursing facilities in all zones. Our nursing facility network is dispersed geographically, providing access to the ALTCS membership countywide. There have been no waiting lists for skilled nursing facility placement nor have there been any transition delays due to capacity issues. There are sufficient skilled nursing facilities in the contracted network to meet the complex needs of the ALTCS population (e.g. members who are ventilator dependent or who have

behavioral health conditions). MCP's network development and contract team will pursue any contracting opportunities as may be necessary.

### **HCBS & Alternative Residential Settings**

#### **Foster Care Homes:**

Through an agreement with the Foundation for Senior Living, MCP has a contract with all available adult foster care homes in Maricopa County. This meets the requirements for all zones in Maricopa County. MCP has an attestation from the Foundation for Senior Living documenting the contracted foster care homes that are available to our ALTCS members.

#### **Assisted Living Homes:**

MCP continues to exceed the AHCCCS network standards for assisted living homes in all zones.

#### **Assisted Living Centers:**

MCP meets and exceeds the AHCCCS network standards in all zones. Currently, the network includes one assisted living facility for which MCP has obtained a waiver from the Single Choice Occupancy Requirement.

#### **HCBS:**

MCP's network of home and community-based services meets the AHCCCS network standards to include Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite. LTC Case Management continuously monitors a "non-provision of service log" that providers complete should a non-provision of service occur. If a non-provision of service does occur, MCP takes immediate action to resolve the gap and the ALTCS team evaluates the situation and if appropriate, makes a recommendation for network adjustments. MCP contracts with the Maricopa County Area Agency on Aging Region I Inc. to provide Home and Community based Services.

#### **Spouse Attendant Care Services:**

MCP continues to support the Spouse Attendant Care service that was instituted in October 2007.

#### **Behavioral Health Services:**

MCP's network of behavioral health providers meets the AHCCCS' network standards and is adequate to meet current and future needs for the ALTCS membership. MCP provides behavioral health services in institutional, home and community-based settings. The behavioral health delivery system includes behavioral health level 1 providers, institution for mental disease, inpatient psychiatric residential facilities, partial hospital programs, intensive outpatient programs and nursing facilities. Home and community-based providers offer a full spectrum of alternative residential settings that include:

- Behavioral Management
- Inpatient Services
- Emergency Care
- Evaluation
- Individual, Group and Family Counseling,
- Medication Monitoring
- Behavioral Health Day Programs/Partial Care

- Psychosocial Rehabilitation
- Adult Foster Care Homes with 24 hour awake staff
- Adult Developmental Homes
- Therapeutic Foster Care Homes
- Alzheimer's Treatment Assisted Living Facilities
- Assisted Living Facilities
- Behavioral Health Group Home - Level II
- Behavioral Health Group Home - Level III
- Child Development Foster Care Homes
- Group Homes for the Developmentally Disabled
- Substance Abuse Treatment Centers and
- Traumatic Brain Injury (TBI) Treatment facilities

## SECTION 4 – IMMEDIATE SHORT-TERM INTERVENTIONS TO ADDRESS NETWORK GAPS

---

MCP has a process in place to regularly monitor the capacity and coverage of the network in order to proactively prevent network gaps. However, if a network gap does occur, immediate steps are taken to address the gap so that no member's care is ever compromised. Descriptions of our process to avoid gaps and short-term interventions are noted below:

### **Process to Prevent Network Gaps**

MCP conducts regular network analysis using numerous monitoring tools to proactively identify and address network gaps. Our provider services team shares results of these network monitoring tools with employees from other departments to gather recommendations to further improve network performance. The Network Strategy and Business Development team researches those areas where service needs are necessary and directs the network development and contracting department to follow up and fill these needs.

### **Addressing Network Gaps**

In the event of a perceived network gap, our provider service representatives (PSR) and contract specialists, in collaboration with the Chief Medical Officer (CMO), the member's CM, and/or other involved parties, immediately assess the availability of other providers in the community. Our preferred intervention strategy is to refer a member to another contracted provider that is qualified and accessible. If that is not feasible, we use the following short-term interventions:

- Coordinate care as appropriate and referral to another contracted provider that can meet the specialized needs of the member.
- *Referral to a non-contracted provider:* We arrange special provisions, such as a letter of agreement (LOA), with non-contracted providers until the member's treatment needs are met, until an equivalent provider is located, or until a contract is finalized with the non-participating provider. We actively monitor the quality of care provided by the non-contracted provider and verify that the provider coordinates with the member's PCP.
- *Recruitment of new provider:* To expedite the contracting process, we have an internal credentialing department that works quickly to credential all new providers. If there is an urgent need for a provider, our credentialing department quickly processes those providers recruited to fill a network gap through the use of an internally conducted, provisional and expedited credentialing process. Our CMO (who is also the chairperson of the credentialing committee) approves provisional credentialing applications within 14 days of receipt of the provider's completed application. Once the practitioner has been provisionally approved by the CMO, the practitioner may begin to care for MCP members. MCP completes credentialing within 60 days of receipt of the provider's completed application.
- *Transportation of a member to a provider outside the member's community:* If there is no appropriate provider available in the member's immediate community, MCP will make transportation arrangements for the member to temporarily receive care from another provider until a more accessible provider can be identified. We monitor quality of care provided and verify that the provider coordinates with the member's PCP.

---

## SECTION 5 – INTERVENTIONS TO FILL NETWORK GAPS

---

MCP uses a proactive approach to network development and management and follows AHCCCS requirements for gap reporting. Our objective is to anticipate and plan for potential future network gaps. It is our experience that network gaps are the result of a contracted provider experiencing a situation which prevents them from providing the service, a provider ceasing to do business, leaving the service area, closing panels to additional members, or loss of credentials. When we identify network gaps, we apply a variety of integrated and comprehensive interventional strategies to resolve the issue. We have worked cooperatively with our providers to develop trust, and our providers know that our owners are a part of the communities they serve.

### **Ongoing Strategies for Filling Network Gaps**

In our efforts to address network gaps, MCP recently re-engineered the Provider Services department to include oversight from the Chief Operating Officer with accountability for:

1. *Provider Services* – a network team that includes a Director, two (2) managers, eight (8) network account managers who support hospital delivery systems which include their related physician organizations, FQHC's, SNF's/HCBS/Residential and ancillary services; and 12 external network consultants/PSRs who support the primary and specialty physician networks in Maricopa, Pima and Santa Cruz Counties. Network account managers are also assigned to any capitated providers or large multi-specialty provider groups. PSRs are assigned based on specialty designation giving them a better knowledge-base of regulatory requirements, payment considerations, and claim trends that may occur in a given specialty, as well as a better understanding of physician practice patterns. This larger, more expanded provider services team meets regularly with practice administrators to validate practice participation, clarifying areas such as additions or deletions in physicians, address changes or new clinic locations, new specialties or services. This information is used to update demographic information in our QNXT™ system which allows us to more accurately identify network changes and gaps.
2. *Network Development and Contracting* - has been expanded to include a network team that includes a director, two (2) network managers and three (3) contract negotiators to ensure necessary and appropriate communications and oversight. This network team works closely with LTC Case Management, Member Services, Provider Services, Quality Management/Utilization Management, Medical Management, Grievance, Pharmacy, Behavioral Health and Claims departments.
3. *Two project managers and a newly created Senior Business Consultant* position - have been added to support the Network Strategy and Business Council. These individuals are accountable for business planning, regulatory reporting, measurement reporting and gap and network analysis, as well as project oversight and implementation.
4. *A Provider Claims Educator* - who is responsible for the production of the materials used to educate providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic funds transfer. This position is responsible for the Mercy Care Plan provider manual and quarterly provider newsletter. Working in conjunction with all Operational departments, the Educator documents trends and guides the development and implementation of strategies to improve provider satisfaction.

These departments coordinate and are responsible for:

- Communicating with the network regarding contractual, program, and administrative changes
- Monitoring provider compliance with AHCCCS policies, rules and contractual obligations to maintain adherence to quality of care standards, member's rights and responsibilities, respecting the member's cultural and ethnic beliefs, use of practice guidelines, coordination with other State vendors (behavioral health, CRS), and following requirements of the grievance and appeals system
- Working seamlessly and cooperatively with the medical directors to evaluate the quality of services delivered by the network
- Avoiding gaps in care, but if any should occur, assisting LTC case management and medical management staff in securing necessary LOA's or other agreements when medically necessary covered services are unavailable for any reason
- Performing root cause analysis on network issues or concerns, including but not limited to: removing unnecessary administrative burdens; reducing avoidable costs to the provider and to the Plan; developing programs to facilitate the use of electronic record sharing and improved communication
- Continually monitoring adequacy, accessibility and availability of our provider network and providing feedback to the team and providers of any findings.
- Tracking and trending provider inquiries, complaints, grievances and information requests to improve our operations and effectiveness, increase accessibility and availability of services and continually improve quality of care.
- Providing web-based and traditional training opportunities and programs to providers – including offering events with continuing medical education credit – that support AHCCCS' mission and the mission of MCP
- Working collaboratively with other MCP departments to identify, track, and trend potential issues and work collaboratively to prevent network gaps and to resolve network issues when they do occur.

In CY2010, MCP developed the Health Plan Operations (HPO) Department to support all aspects of internal Operations for the Plan. The HPO Department is overseen by the Chief Operating Officer and encompasses the following focus areas:

1. Research and Resolution – team of one (1) manager and six (6) analysts evaluate and research provider inquiries, claims edits and denial trends
2. Product Management – team of one (1) manager and eight (8) Product Specialists and Analysts that are responsible for reviewing product (line of business) requirements, system configurations and monitoring of audit results
3. Provider Records Management – team of one (1) supervisor and eight (8) Provider Representatives that are responsible for system updates to provider records, oversight of the PAT reports and encounter file reviews
4. IT support – team of one (1) manager and three (3) programmers who assist with the development of reports to support business practices, monitoring of productivity.

We are scalable in our resources and continually reevaluate staffing to meet service needs.

## Action Plans

The Strategy and Business Development Council meets every other week to discuss and prepare action plans that address and improve the provider network. Detailed business strategy is included in each plan and includes:

- Network overview
- Geographic location of membership and providers
- Current State versus Future State requirements
- Non-Participating provider volume
- Medical Management Guidelines
- Prior Authorization requirements and changes
- Recommendations for changes
- Timeline for implementation and,
- Impacts to members and providers

Once an action plan has been approved, a detailed implementation plan is put into place and is communicated to internal stakeholders at varying intervals throughout the project implementation. The Network Strategy and Business Council are responsible for project oversight and reports results, progress or barriers to the executive council.

## Non-Financial Incentives

To help maintain a consistent, stable network on an on-going basis, MCP offers a number of “non-financial” incentives to providers, including:

- A simplified, prior authorization or referral process. Providers can now submit prior authorization requests via an on-line, real time process through a secure provider portal that tracks turnaround time and offers documented completion by e-mail notification.
- A process to ease administrative burdens for the provider, such as EDI claim transmissions.
- A process to enhance cash flow to the provider through electronic fund transfers.
- An electronic remittance advice to expedite account reconciliation.
- LTC Case management to assist providers with complex member issues.
- Disease management programs assist our providers with better reporting tools and staff support which results in improved outcomes for those who care for members with chronic illnesses.
- On-line Epocrates® formulary look up.
- 24/7 access to customer service staff to assist members/providers.

- MCP Providers have access to specialty trained PSRs that are highly skilled in serving the provider populations they are assigned to assist.

### **On-Going Strategies**

MCP is implementing a number of strategies which are expected to enhance our existing network. These include:

- Strengthening relationships with FQHC's, PCP's and Specialists to promote positive collaboration between MCP and the provider network
- Creating a focus on pay-for-outcomes payment model that engages providers to offer after hours care, meeting certain clinical quality metrics and which encourages high-quality care and appropriate utilization
- Collaborating with FQHC's, PCP's and Specialists to create stronger care management and disease management programs for members with complex needs
- Exploring programs, pilots or technology that will assist the Plan in re-directing members to better after hour care options other than hospital emergency rooms
- Offering better data tools to providers that document member utilization, pharmacy use, and gaps in HEDIS, immunization or disease prevention screenings.
- Identifying opportunities to engage or incentivize members in healthcare outcomes
- Recruiting additional home and community-based providers targeting certain geographic areas which adequately service all cultures;
- Maintaining a HCBS provider network that allows members to remain in the least restrictive setting, and to prevent any service gaps and allow long term care members continuity of care and the ability to age in place
- Building a network that allows members to receive services in their residential setting, e.g. SNF, ALF, or the members own home.
- Training "specialized" Provider Services Representatives to best meet the needs of the HCBS and SNF providers.

### **Identifying Barriers to Successful Network Development**

While MCP has experienced success in filling network gaps through its short-term and on-going interventions, there are a number of circumstances and influences that create barriers to efficient network deployment. These include:

- Work force shortages in all areas of health care in rural and urban settings. This shortage is particularly exacerbated by Arizona's rapid population growth along with the seasonal migration during the winter months.
- Unwillingness of some providers to see Medicaid members due to burdensome administrative/paper work requirements, low reimbursement rates, and difficult to manage or high medical acuity patients. Additionally, the medical fragility of some ALTCs members, and the demands of their caretakers, sometimes creates unwillingness on the part of some providers to care for highly complex members.
- The consistent decline in reimbursement has caused providers to close their member panels.
- Shortage of nurse practitioners and PCPs interested in treating home bound members.

- Despite these challenges, MCP continues to develop effective strategies to mitigate these barriers, providing its ALTCS members with the most consistent, comprehensive and responsive network which offers choice, dignity, independence, individuality privacy and supports self determination to meet their specialized needs.

### **Overcoming Barriers for Efficient Network Development**

There are a number of approaches that MCP is utilizing to mitigate these barriers including:

- Coordinating with owner sponsors, Catholic Healthcare West and Carondelet Health Network to recruit providers locally or nationally that may be willing to fill network gaps in Arizona
- Collaborating with FQHCs or Rural Health Clinics (RHC) to expand satellite sites to fill network gaps in rural areas
- Simplifying prior authorization requirements in areas where network gaps may prevent the delivery of local care for members
- Increasing provider education and outreach efforts to communicate network gaps and solicit help from current providers
- Soliciting assistance from the Member Advisory Councils to identify providers willing to fill network gaps

### **How AHCCCS can best support MCP in our efforts to fill Gaps**

- Accepting different payment methodologies that are outside of the present fee-for-service model.
- Allowing payment for codes such as after hours care and disease management programs which incentivize providers of care to improve service to our members with more complex needs. Key activities of the medical home are not reimbursed, such as improved and more frequent communication between the practice and patients. Medical homes typically result in 25% to 30% more labor costs. Operational changes to support a medical home increases costs, which makes it imperative to develop an appropriate financial model that rewards primary care physicians appropriately.
- Identifying ways to encounter payments to providers for financial incentives, education and non-covered codes.
- Updating provider types to better reflect provider specialty such as hospitalists and pain management
- Add revenue codes for skilled nursing facilities to better reflect the specialized levels of care offered to members (e.g. dialysis)
- Allow HCFA claim form types in a nursing facility place of service (following CMS regulations) and allow claims to encounter
- Follow CMS payment methodology for DME equipment (monthly rental versus daily)
- Allow case management services and behavioral health Category of Service (COS) to better support integrated care models.
- Allow Medicare RUG codes of 0120 or 0022 to indicate member responsibility (rather than using an ALTCS Revenue Code) for encounters
- Allow members to be assigned to clinic locations rather than physicians for FQHC's and Patient Centered Medical Home providers

## SECTION 6 – OUTCOME MEASURES AND EVALUATION OF INTERVENTIONS

---

MCP systemically evaluates the overall adequacy of the network by:

- Quarterly review of GeoAccess data with the Provider Services team to compare our network to the addresses of our members and the AHCCCS' network standards to ensure network requirements are met and member needs are met. As a result of these indicators, MCP has added PCPs and specialists to the network and developed a comprehensive network to meet all member needs.
- Reviewing the member-to-primary care physician ratio while taking into consideration PCP capacity including panel status (reports are generated which measure capacity for each PCP). MCP uses the AHCCCS report identifying primary care physicians with more than 1,800 assigned members to evaluate the providers entire panel size and evaluate the PCPs ability to service members.
- Analyzing the results from the annual review of our providers' compliance with accessibility standards, including PCP and Specialty appointment availability, wait time in office, telephone and after hours accessibility, and other key performance measures. We send a letter to providers who do not meet one or more of the standards explaining the contractual requirements and provide them with 30 days to correct the deficiency. We continue to monitor these providers, and if the provider fails to respond or correct the deficiency after the 30 days, a medical director visits the provider to reinforce the message or to work collaboratively with the provider to assist them to meet the program requirements. If the provider continues to fail to comply with the requirements necessary to meet the needs of our members, we may restrict future enrollment or terminate the contract. As a result of these measures, MCP has successfully maintained a stable network which meets all contract requirements.
- Annually conducting satisfaction surveys of providers following NCQA requirements and reviewing results for improvement opportunities. As a result of this information, MCP implemented its specialized provider services teams, redesigned our website to be more interactive and helpful to our providers and implemented additional mechanisms for our providers to share information routinely via the provider postcard ("What Can I do for you") from which comments are tracked and trended and action plans developed.
- MCP embraces a continuous quality improvement philosophy and process that includes a multi-departmental, comprehensive approach to measuring outcomes and evaluation activities. We recognize that member and provider feedback are key indicators of operational effectiveness in providing quality care to members. We maintain multiple opportunities for both members and providers to provide this information and to participate in system enhancements. MCP incorporates member and provider feedback into monitoring activities to drive operational changes and improvements that increase the quality of member care.

## SECTION 7 – ONGOING ACTIVITIES FOR NETWORK MANAGEMENT

---

In efforts to improve our ability to identify network issues early, MCP re-defined the way that the Health Plan worked with its provider network. Significant changes in the organizational structure, internal training resources and oversight have greatly improved the relationship between the plan and the contracted provider's satisfaction with the health plan. MCP continues our improvement efforts in CY2011 to:

- Develop and maintain a provider network to meet the needs of the current members which exceeds the requirements of the ALTCS program allowing for projected growth in the additional GSA and growth in the current program
- Strengthen its provider network through stronger provider contracting efforts
- Define the network requirements through strategic planning, measurement reporting and financial analysis
- Create provider administrator forums driven by provider specialty to better define the care continuums and service delivery
- Integrate contract measurements and reporting into daily operations; use this data to better manage health care expenses and improve the cost of delivering care to MCP membership
- Partner with the provider network to create pilot programs that best serve members in special healthcare populations
- Review our contracting language to identify opportunities to improve effectiveness by streamlining processes, and increasing efficiencies in health plan resources
- Continue building partnerships and working collaboratively with providers to develop efficient/effective ways to meet the needs of our members
- Proactively review the network to project future needs which allow flexibility in serving increased membership and which improves the quality of service offered to members
- Ongoing activities to manage the network depend on the results obtained from provider monitoring efforts and internal and external communications activities including, but are not limited to, the following:
- Verifying that services are provided in accordance with AHCCCS standards – Based on results from MCP's Annual Accessibility Assessment; we send letters to providers who fail to comply with appointment availability standards. We develop corrective action plans, if necessary, to assist providers in achieving compliance. Providers have 30 days to correct the deficiency and then are reassessed.
- Addressing current and future network gaps –Based on results from GeoAccess and member complaints, appeals and grievances, we contract with alternative providers, track and trend increases in provider type demand, and solicit identification of potential providers from members, providers and the community.

- Addressing member concerns regarding providers – On a real-time basis, provider services (or quality management for quality of care concerns) follow up with providers regarding member-escalated concerns. In addition, the provider services department reviews monthly, trended grievance reports to identify overall network needs or performance issues for specific providers.
- Improving and maintaining the quality of services delivered by providers – As a result of trends in clinical or service performance indicators, MCP may implement broad-based provider interventions such as: 1) Creation and dissemination of educational materials and evidenced-based practice guidelines, 2) Outreach efforts to encourage preventive health care (e.g. Health Risk Assessments), and 3) Member education programs.
- Facilitating operational changes that promote network effectiveness – To address provider concerns to minimize administrative hurdles, MCP developed and implemented a process through which providers can use our website for prior authorization.
- Assisting in filling immediate network needs –MCP may implement a single case letter of agreement with a non-participating provider, grant provisional credentials, or transport members to a provider in another geographic location to address immediate member needs.
- Conducting provider focus groups, to review patterns of provider complaints and member grievances, and reviewing ongoing input from providers’ sites.
- Collecting and tabulating information from other departments, including case management, medical and quality management, appeals, claims and member services on an ongoing basis to ensure we all have the opportunity to hear the “noise” and provide MCP the opportunity to address issues early on before they have the opportunity to exacerbate.

Using the results from the information and data sources listed above, MCP modifies our network development action plans as necessary, to reflect successful closure of gaps, the addition of newly targeted areas for network improvement, and/or the changes to the type of intervention strategies being employed. Each evaluation methodology is continually reviewed to determine the effectiveness of any interventions.

### **Interventions to Address and Reduce No-Show Rates**

MCP provides proactive education to providers and members regarding the importance of keeping appointments, and offers assistance to providers in helping to avoid future missed appointments. We notify members of their responsibility to keep appointments through the Member Handbook, member newsletters, website, and during discussions with CMs for those assigned to case management. We discuss no shows with providers during the initial orientation and routine site visits, encourage providers to make appointment reminder calls to members, encourage them to refer no shows to us through the provider assistance program (described below), and provide further information in our Provider Manual and on the website.

We have a provider assistance program where we work with providers to measure missed appointments and lessen future occurrences. Under the program, the provider submits a form to notify us of one or more missed appointments. All such notices are routed to member services for documentation and follow up. Our member services department reaches out to those members to provide education regarding the importance of keeping appointments, and may refer members to case management for intervention by a CM, especially if a member’s care is jeopardized due to missed appointments. If the member continues to miss appointments, the provider has the option to remove the member from their panel. In these instances, the physician notifies the member of removal from their panel and provides a 30-day transition period.

## SECTION 8 – COORDINATION INTERNALLY BETWEEN DEPARTMENTS

---

MCP recognizes that effective network development and management requires communication and coordination within its own organization, as well as with outside organizations that affect the delivery of services to its membership. Input obtained through coordination/communication activities is continually used in the development and maintenance of the network and the annual Network Development and Management Plan.

Although our provider services department has primary responsibility for managing the network, MCP staff from medical management, case management, quality management, grievance and appeals, compliance, claims and member services work cooperatively to review results across monitoring tools and implement activities that improve the network. We gather information from several sources, including 1) provider and member complaints, appeals, and inquiry analysis; 2) satisfaction survey results; 3) provider appointment availability and after hours survey data; 4) GeoAccess surveys; 5) provider site visits; and 6) interactions with other departments.

Interdepartmental communication is an essential part of MCP's network monitoring and management activities. We promote departments to share provider issues across the organization by providing organized and systematic opportunities for departments to collaboratively discuss provider issues and contribute to MCP-wide resolutions. Communication avenues include work groups, formal committee meetings, and informal daily interactions.

### **Internal Coordination**

MCP's key personnel from various departments work together through interdepartmental work groups to discuss provider issues and implement actions for improvement. Work groups include staff from multiple areas such as provider services, contracting, claims, appeals, operations, member services, medical management, quality management, and long term care. Topics covered include:

- Member grievances – Staff meet weekly to address escalated member-initiated concerns regarding providers, [Quality of care, accessibility or availability of care]. Provider services (or quality management for quality of care concerns) meet with providers and report feedback at weekly meetings. In addition to real-time follow up, MCP produces a monthly grievance report that identifies the type of grievance, including trends that indicate potential network need versus a performance issue of a specific provider. The provider services department reviews the report and identifies any further network intervention opportunities.
- Member appeals and provider claims disputes – Staff meets weekly to review member appeals and provider claims disputes, including trended data, which often involve denials of service and/or coverage determinations. This group researches claims issues down to the root cause, which may be due to incorrect provider claim submission, a provider add/load issue, or system set up issue where the claim was not set to pay according to the provider's contract.
- Long term care – Provider services staff meet with the long term care department on a bi-weekly basis to update and prioritize network concerns and initiatives.
- Operational meetings – Meetings are designed to prioritize and implement strategies surrounding contract implementation, claims payment, and problem resolution. Topics such as claims editing, audit findings, claim projects, system configurations, and provider data are reviewed.

- Joint Operating Committee (JOC) meetings – Provider services and staff from other MCP departments meet with hospitals, FQHC's, skilled nursing facilities, and ancillary providers on a regular basis to communicate information, gather feedback, and resolve issues.
- Strategy and Business Development Council – This team includes the executive leadership team from all MCP departments. It meets biweekly to discuss business strategy and prepare action plans that improve the organization, including the provider network. The Executive Council assigns action plans to the Network Strategy and Business Council for implementation.

### **Cross-functional Committees**

Staff level workgroups share information about their findings and activities through MCP's formal management committee structure. Committees are cross-functional and include management from departments across the organization. Committees review results from monitoring tools and departmental workgroups and make recommendations regarding managing the provider network. Committees communicate provider issues and action plans to Executive team decision makers from the appropriate departments, who in turn implement actions through workgroups or other means. Major MCP committees are:

- Quality Management/Utilization Management Committee (QM/UM Committee) – Chaired by our chief medical officer (CMO), this committee advises and makes recommendations to the CMO regarding the quality of care and service provided to members and the oversight and maintenance of the utilization management program. This committee reports to the Board of Directors.
- Credentialing Committee – Chaired by the CMO, this committee reviews the credentialing and re-credentialing of providers for participation in the MCP network including their selection, approval, or denial. This committee reports to the QM/UM Committee and the Board of Directors for final review/approval.
- Quality Improvement Committee (QIC) – Chaired by the Director of Quality Management, this committee oversees compliance with AHCCCS and CMS quality improvement strategies and advises the CMO and the COO on quality improvement strategies pertaining to providers and members. This committee reports to the QM/UM Committee.
- Pharmacy & Therapeutics Committee (P&T) – Chaired by the CMO, this committee makes recommendations regarding MCP pharmacy services including, but not limited to, developing, maintaining and updating the preferred drug list, reviewing drug utilization data, and making recommendations regarding member education materials and programs. This committee reports to the QM/UM Committee.
- Member Advisory Council – Chaired by the member services director, this council is comprised of acute and ALTCs members (6 acute, 6 ALTCs) members and is supported by MCP member services, quality, and provider services personnel. The council meets quarterly to review MCP activities, member communications, program interventions, and general services for our members. Meetings are facilitated by our member services department, which submits recommendations and meeting summaries to the MCP Quality Committee.

### **Informal Communication through Daily Activities**

MCP personnel work informally to review findings and to identify and resolve issues through daily interactions with other departments. For example, employees from medical management, quality management, or member services may identify network gaps during routine activities. When this occurs, employees work with our ALTCs contract specialists to identify contracted providers available to provide

necessary services. If a contracted provider is unavailable immediately, medical management may authorize and coordinate care with nonparticipating providers, and report network needs to the contracting department for follow-up.

## SECTION 9 - COORDINATION WITH EXTERNAL COMMUNITY AGENCIES

Collaboration leads to an effective continuum of care. MCP understands the changing way that people are receiving healthcare. To help achieve this goal, MCP has strategically partnered with organizations that provide coverage and care at convenient locations and at lower costs. MCP coordinates and collaborates with Community Agencies to best serve our members. Recent examples of our collaborative efforts include:

- Contracting with Inspiris in Maricopa GSA and Tucson House Calls and Triad Medical Group in the Pima and Santa Cruz GSA to offer primary care to members in skilled nursing facilities or other residential settings 24-hour-per-day, 7-days-a-week.
- Developing an urgent care network throughout Maricopa, Pima, and Santa Cruz GSAs that offers specialized, focused urgent care facilities which improves access to after-hours care.
- Building upon our strong commitment to patient centered medical homes (PCMH); MCP recently launched a PCMH Pilot for our ALTCS members assigned to the St. Joseph's Family Practice Clinic in Maricopa County. The PCMH concept is an exciting and promising approach for providing highly coordinated and responsive care to ALTCS members. MCP will launch ten additional PCMH sites in Maricopa and Pima Counties during CY2011.
- Launching a diabetes management program in 2011, in conjunction/collaboration with the Carondelet Medical Group and the University of Arizona in Pima County. This program focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and telehealth monitoring for at risk members.
- Expanding of our behavioral health network and programs in Maricopa, Pima, and Santa Cruz GSAs through collaboration with Community Partnership of Southern Arizona (CPSA). In our efforts to remain responsive to members with behavioral health and co-morbid conditions we have executed an agreement with the Community Partnership of Southern Arizona (CPSA). As a result of this agreement we are further expanding our behavioral health expertise and broadening services to enhance and improve our already excellent behavioral health network for ALTCS members. CPSA's Consultation and Clinical Intervention Team is an innovative approach for assessing members at high risk for placement disruption and designs services to meet members' specific needs.
- Improving services to homeless members in Pima County through the Southern Arizona Health Village for the Homeless Van of Hope community partnership. This program provides mobile medical services at sites frequented by homeless members.
- Strengthening our long-standing relationships with FQHCs in Maricopa GSA, including Adelante HealthCare, Maricopa Integrated Health System, Mountain Park Health Center and Wesley Community Center. We also have long-standing and effective agreements with FQHCs in Pima and Santa Cruz GSA, including El Rio Health Center, Marana Health Center, Mariposa Community Health Center, Desert Senita Community Health Center and United Community Health Center.
- Partnering with our HCBS providers/vendors by holding ongoing meetings to improve our communications and to provide an open forum for our collaborative efforts to best meet the needs of these providers to assist them in their ongoing efforts to meet the needs of our members.

- Contracting with the area agencies in Maricopa, Pima and Santa Cruz counties in efforts to support them financially and to work collaboratively to develop new and innovative measures to meet member needs.
- Collaborating with the respective Area Agency on Aging programs in Maricopa County and Pima Counties to manage the Community Transition Services program. This program allows any member who has been living in a skilled nursing facility for at least 60 consecutive days to transition to a HCBS setting (such as a home or apartment) to receive up to \$2,000. The funds are limited to a one time authorization per five year period and must be available 30 days prior to a planned discharge and will remain available for 90 days from the date of discharge from the institutional setting. Community Transition Service funds can be used for, but are not limited to:
  - Security deposits that are required to obtain a lease on an apartment or home
  - Essential furnishings, such as a bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances
  - Moving expenses required to occupy a home or apartment
  - Set up fees or deposits for utility or service access
- Working collaboratively with AHCA and their director to maintain effective communications and to identify opportunities that support them in their efforts to serve our members.
- Co-Sponsoring the 15<sup>th</sup> Annual Caregiver Consortium with the Pima Council on Aging. The Consortium was attended by over 400 Caregivers. Gail Sheehy, a nationally-known, best-selling author and caregiver, was the Keynote speaker. MCP and Carondelet Health Network will sponsor the PCOA Gala in April 2011. The Gala will, in part, fund the “PCOA for All” Attendant Care Program in Pima County.
- Supporting the Caregivers Training Institute’s (CGTI) Caregiver Work Force Development program. CGTI has been a key instructional provider with an exceptional record of producing screened, trained and well-qualified health caregivers since 2001.
- Through a partnership with CPISA, MCP is implementing a comprehensive clinical intervention team (CCI). This program is a template for integration, cooperation, collaboration, innovation and creativity to better meet the needs of the behavioral health members while ensuring effective and efficient utilization of health care resources. This model identifies members with frequent ED visits, hospital admissions, acts of self-harm or harm to others, arrests or police interventions, acts of property destruction, or crisis calls to BH providers. Participating in this program shall enhance the behavioral health of the ALTCS members. This CCI team provides expertise in behavioral issues, through the completion of a comprehensive functional analysis and behavioral plan for members identified as being at high risk for placement disruption or hospitalization. The expected outcome of the program is a reduction in ER visits, hospital admissions, and hospital inpatient days for behavioral members involved with the CCI program.
- This creative community partnership program serves as a useful, cost effective program for the care of high risk/high utilizing members of the ALTCS system. By providing a multidisciplinary, interagency process for the evaluation, treatment and oversight of behavioral members who have been historically difficult to treat, the CCI Team model increases placement stability, reduces costs, allows successful treatment in the least restrictive levels of care, promotes positive outcomes and create a system of integrated care and interagency cooperation. Data trends will be routinely evaluated and program outcomes measured to ensure the program is

meeting the needs for these ALTCS members with specialized needs, ensuring effective and efficient utilization of health care resources.

## SECTION 10 – NETWORK DESIGN

### **Continuity of Care and Member Transition in Network Design**

MCP is actively pursuing agreements with providers who contract with the current incumbent in Pima and Santa Cruz counties. We anticipate that we will secure signed agreements with these providers by October 1, 2011. However, in the event that some providers remain non-contracted by this date, MCP has a process to provide for continuity of care and avoid transition to another provider. We will accomplish this by arranging for single case letters of agreement with the existing provider while we continue to work to finalize an agreement or until the member has completed their care with the provider. As a last resort, when medically necessary, MCP may transfer the member to a qualified and available contracted provider. During the transition process, the MCP CM assigned to each member will verify that we preserve the continuity of care and that we have implemented a seamless transition.

MCP maintains a provider network designed to meet the unique and complex needs of the Medicaid population, as demonstrated above in the section regarding network status and gaps. In accessing the network, our goal is to assist both members in the general Medicaid population (AHCCCS) as well as those with long term care needs (ALTCS).

### **How Members Access the System**

Our flexible service delivery system is designed to allow easy navigation and to ensure members, have access to and choice of, services to meet their needs in terms of timeliness, duration, amount of and scope of services. MCP strives to allow members to receive necessary care when and where the service is needed. Members are able to select the PCP that best fits their medical history, geographic location and personal needs. In addition to making appointments directly with their PCPs, members are able to self-refer for annual well-woman exams, family planning and dental services. Members have easy access to transportation when necessary, by calling MCP to arrange transportation to necessary medical services. Emergent access to the delivery system is available through the extensive array of contracted emergency and urgent care providers. Should a member receive emergency care by a non-contracted provider, MCP pays the AHCCCS Fee for Service Rates. Additionally, MCP makes care accessible to members who are unable to make an office visit due to medical or behavioral conditions, through contracts with providers who are willing to visit the member in their own home, ALF or SNF residence.

To ensure easy access to PCPs, our primary care physician contracts require after-hours call availability, same day appointments for members with urgent conditions, and routine appointment availability within 21 days. In addition, MCP contracts require that patients not wait more than 45 minutes from their scheduled appointment time to see their PCP in accordance with the AHCCS/ALTCS requirements for appointment availability to allow members to easily access the system. The onsite monitoring performed by provider services representatives validates that these requirements are met. MCP has documented a very high level of compliance with these requirements. For example, accessibility monitoring shows 99% compliance for routine PCP appointments within 21 days. We contract with a large network of urgent care facilities, and have 24-hour customer service staffing to make certain members can access assistance locating an appropriate provider 24 hours a day, seven days a week.

We provide each member with an explanation on how to access the provider network through various sources, including:

- New member packets are mailed to all members within 12 business days of enrollment
- Member handbook in hard copy, as well as availability on our website 24/7

- MCP enhanced and expanded website which is available 24/7
- Information provided by the member's CM on an ongoing basis
- Member newsletters
- Member services/customer service staff available 24/7, toll free

Our provider directory, which identifies all current providers by specialty, is available to members in printed form as well as on our website. All MCP contracts for specialty services require that members have easy access to appointments so that emergency visits are available within 24 hours, urgent within 3 days and routine appointments are available within 45 days. In addition, contract language requires that members not wait more than 45 minutes to see their provider, except in cases of an emergency. Provider staff monitor on site to ensure these appointment standards are met, and if necessary identify opportunities for improvement to enhance our members access to the system.

In addition, the member service center is available 24 hour-a-day, 7 days-a-week to respond to a member's inquiries or requests for information. We offer a Language Line to assist members who have limited English proficiency (LEP) as well as to assist providers serving our LEP members. During the initial contracting process, MCP captures information to identify and track any language(s) spoken by each provider. We publish this information in the MCP provider directory for ease of our members, to assist them in selecting a provider to best meet their needs. Languages spoken by providers are also found in the MCP business application system, allowing member services to readily identify providers who speak other languages to better serve the member's language and cultural needs. Our PCPs as well as other MCP staff such as CMs, disease managers, and member services representatives also play a key role in educating members about the network and facilitating access to needed services. In the isolated instances when a member may encounter a problem, issue or concern, we have a timely, responsive and helpful grievance and appeals system.

A member's CM is also a valuable source of information about the network and how to access care. The CM assists the member/member's family in understanding how to access care and make full use of the available network. These services are provided when performing the initial assessment, developing the care plan, advocating for the member and performing scheduled and unscheduled visits. Members have access to a wide variety of LTC services which are available through the member's CM. Each member is assessed to identify their specific needs and a care plan is developed to meet the needs of each member. These LTC services include a wide array of Behavioral Services and Residential Services in addition to Home and Community Based Services. The CM works with the member and their family to develop a specialized care plan to meet the specific needs of the member and maintains them in the least restrictive setting

### **Relationships between Various Levels of the System**

Members are encouraged to make appointments with their PCP and in turn PCPs are contractually required to schedule appointments with their assigned members. The PCP may make referrals to various provider specialties and services including but not limited to laboratory, radiology, durable medical equipment or home health, etc. When specialty services are warranted, the PCP simply refers the member to an appropriate specialist to best meet their needs. The specialist also may make referrals to various provider specialties and services including but not limited to laboratory, radiology, durable medical equipment or home health services, to serve the member in meeting their health care needs. Both PCP's and specialists may write prescriptions for medication needs. Members have access to a full pharmacy network near their home, or within the SNF to obtain their prescription medication(s). MCP encourages providers to participate in E-Prescribing to simplify the prescription process for members.

Members may access a full network of skilled nursing facilities through a referral or authorization from either a PCP or specialist or, after consultation with their provider may be referred to a skilled nursing facility by their MCP CM, should this level of care be appropriate to best meet the member's needs. MCP has contracts with providers that will offer primary care services within the SNF, assisted living or other residential settings. This results in a reduction in patient admissions, re-admissions, transportation expenses and allows the member easy access to PCP care. This partnership supports our goals to allow members to remain within their home location and provides easy access to care.

A large network of urgent care facilities is available to all members in Maricopa, Pima and Santa Cruz Counties. These services are easily accessible as they may be obtained without a referral or authorization from their PCP or provider specialist. MCP collaborated with the NextCare Urgent Care Centers to create three specialized, focus urgent care facilities staffed by Board-Certified providers and supported by experienced mid-level providers. MCP works closely with the staff at NextCare to improve access to after hours care, and to evaluate opportunities for further expanding specialized Urgent Care Programs.

Hospital services may be accessed once a determination has been made by either a PCP or provider specialist that a higher level of service is needed. Members may also access hospital services through the emergency room for emergent situations. Members are educated to contact their PCP prior to going to the emergency room, however; if the member determines that their situation requires an emergency room visit, no authorization is required for these services.

MCP contracts with surgery centers to allow surgical services, when medically appropriate, to be provided at a lower cost setting than at higher rate outpatient hospitals. MCP contracts with specialists who have privileges at these surgery centers which ensure this cost effective option is available to our members.

### **Listing/Description of the Available Alternatives to Nursing Facility Placements**

MCP has a wide array of assisted living facilities including AFC, ALC, ALH and behavioral homes as further described in this plan and in our Network Submission. This network far surpasses the requirements of the ALTCS bid. These services in addition to HCBS Services are available through the member's CM.

An Assisted Residential Facility (ARF) is a residential care institution that provides or contracts to provide supervisory care, personal care, or directed care on a continuing basis. Types of assisted residential facilities include: **adult foster care homes**, where care is provided for up to four people in the home in which the caregiver lives, **assisted living homes**, which provide care for up to 10 people, and **assisted living centers**, which provide care for 11 or more people.

Currently 15.5 percent of MCP's membership in Maricopa County resides in an ARS setting; in Pima County, while 16 percent of our members are living in an ARS setting.

MCP has a large network of HCBS providers. Currently:

- 76% of our membership lives outside of the nursing home.
- 83% of our membership is receiving attendant care.
- MCP recognizes that family members are a significant component in the success of the members in home placement. MCP case management staff take action to support the family caregivers. MCP supports a very high percentage of family caregivers to best serve

our members needs. Currently 59 percent of the MCP members receiving caregiver services are receiving them from family caregivers.

MCP's comprehensive monitoring program for members' in-home services is based on reviewing our network continuously for attendant care, personal care, homemaker, and respite care. There is a bi-monthly meeting between the Long Term Care Management Team and Provider Services Representatives to review and discuss any current needs/gaps in the network.

The following tables list MCP's Assisted Residential Facility Providers and HCBS providers by GSA.

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
3RD STREET HOME
51ST DRIVE HOUSE
56TH LANE HOUSE
A LANE ADULT CARE HOME
A & A FAMILY CARE ELDERLY
ABUNDANT LIVING I
ABUNDANT LIVING II
ABUNDANT LIVING III
ACAPULCO ADULT CARE HOME
ACOMA HEALTHCARE
ACTIVE LIFESTYLE HOME CARE
ADAMS HOUSE INC
ADAMS HOUSE INC
ADVANTAGE HOME CARE LLC
ALAMAN, MARINELA AFC HOME
ALERT ADULT CARE INC
ALICE HOUSE
ALMS TRANSPORT (PART OF CARING OF HEARTS)
ALWAYS COMFORT CARE ASSITED LIVING HOME
AMETHYST ARBORS ASSISTED LIVING
AMETHYST GARDENS
ANGEL CARE HOME
ANGEL COUNTRY CARE
ANGELS REAL HOME CARE
APOLLO ASSISTED LIVING
ARDC SCOTTSDALE HOME

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
ARIZONA DESERT FALLS
ARIZONA MENTOR AZTEC
ARIZONA MENTOR CAMBRIDGE
ARIZONA MENTOR CHESTNUT
ARIZONA MENTOR CURRY
ARIZONA MENTOR CURRY
ARIZONA MENTOR DESERT WIND
ARIZONA MENTOR ECHO
ARIZONA MENTOR HORIZON
ARIZONA MENTOR KEATS
ARIZONA MENTOR KEATS
ARIZONA MENTOR MEADOWBROOK
ARIZONA MENTOR UNION HILLS
ARIZONA MENTOR VERLEA
ARIZONA MENTOR-HAWTHORNE
ARIZONA MENTOR-HAWTHORNE
ARK OF ANGEL ASSISTED LIVINGS
ASHLEECARE
ASHWORTH, ANNE AFC HOME
ASSISTED LIVING LIFESTYLES LLC DBA SENIOR PARADISE LIVING
ASSISTED LIVING OF AZ
ASSISTED LIVING OF PARADISE VALLEY
ASSISTED LIVING-PHOENICIA
ASSITED LIVING AT MOUNTAIN VISTA INC (TBI)
ATC BEST OF CARE
ATUDOROE, VIOLETA AFC HOME
AUMAN, SHIONE AFC HOME
AURITA, TERESA AFC HOME
AURORA HOUSE
AUTUMN YEARS CARE CENTER
B AND H ADULT CARE HOME II
BAKER, SANDRA AFC HOME

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
BALDWIN HOUSE
BANDALIER HOUSE
BAPTIST VILLAGE
BAPTIST VILLAGE THUNDERBIRD
BARBAROSIE, LIVIA AFC HOME
BARTOSZEK, HELENA AFC HOME
BAYLON, CAROLINE AFC HOME
BEAL, SULON AFC HOME
BEATITUDES CAMPUS OF CARE ALC
BEAUTIFUL BEGINNINGS ALH
BEAUTIFUL BEGINNINGS ALH
BEHREND HOUSE
BETHANY HOME ADULT CARE
BETHESDA GARDENS
BETTS CARE & RETREAT LLC
BIG SKIES
BLOOMFIELD HOUSE
BLOOMFIELD HOUSE
BLUE SKY MANOR INC
BLUE SKY MANOR INC
BLUE SKY MANOR INC 3
BOHA, DANIELA AFC HOME
BOWERHAVEN, LLC
BRANNAN HOUSE
BRILLIANT CARE HOME INC
BRYCE HOUSE
BUGGADII ASSISTED LIVING HOME
BURKESHIRE RETIREMENT HOTEL INC
BYERHOFF, BEVERLY AFC HOME
CABOT HOUSE
CACTUS GLEN CARE HOME
CACTUS VILLA
CALVIN, MELVA AFC HOME
CAMERON HOUSE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
CAMINONG, GIL AFC HOME
CAMIS ADULT CARE
CARDOZA, MARTY AFC HOME
CARE FIRST
CARE WITH LOVE-7022
CARE WITH LOVE-813
CARING OF HEARTS OF AZ, LLC
CASTANOS, LUCAS AFC HOME
CASTILLO, ANITA AFC HOME
CAVE CREEK HOUSE
CAVEO ASSISTED LIVING LLC
CHAPARRAL WINDS ASSISTED LIVING
CHEERFUL LIVING HOME
CHERRY HILLS HOUSE
CHRISTIAN ADULT CARE HOME
CHRISTIAN CARE ASSISTED LIVING CENTER PHX
CHRISTIAN CARE FELLOWSHIP SQUARE MESA
CHRISTIAN CARE MANOR II
CHRISTIAN CARE MANOR IV
CHRISTINE PLACE APARTMENTS
CHRISTINES ROSE GARDEN H
CIUPE, EMILIA AFC HOME
COMFORT GIVERS
COMFORT HAVEN OF MESA
COPPER HEIGHTS ASSISTED LIVING
CORONADO RANCH
COUNTRY VIEW ESTATES
COURTYARD TOWERS
CREATIVE INNERVISIONS LLC
CREATIVE INNERVISIONS LLC
CREATIVE INNERVISIONS LLC
CREEKVIEW MANOR
CREST LANE HOUSE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
CROCUS RESIDENTIAL
CYPRESS COURT AT MESA
CZERSKI, JADWIGA AFC HOME
DALLAS SPECIALIZED CARE
DE DIOS, EDUARDITO AFC HOME
DES MOINES SPECIALIZED CARE
DESERT JEWEL HOUSE
DESERT SKY HEALTHCARE AND REHAB (ALC)
DESERT SPRINGS SENIOR LIVING COMMUNITY
DESERT VIEW ADULT CARE HOME
DESERT VIEW ALH 2
DESERT WINDS ASSISTED LIVING, LP
DESTINY ASSISTED LIVING HOME
DEVEREUX RES TREATMENT
DIONNE'S ASSISTED LIVING HOME, LLC
DIVINE GRACE ASSISTED LIVING HOME
DK ADVOCATES INC
DORSETT, GLORIA AFC HOME
DRZEWIECKA, MYRA AFC HOME
EFFECTIVE CARE FOR ELDERL
EL CAMINITO HOUSE
EL MIRAGE GROUP HOME
ELDER KARE OF AMERICA
ELENAS LOVELY ADULT CARE HOME
ELITE ASSISTED LIVING HO
EMERITUS AT GLENDALE
EMERITUS CORPORATION DBA THE ARBOR AT OLIVE GROVE
EMERITUS CORPORATION DBA VILLAGE OAKS CHANDLER
EMERITUS CORPORATION DBA VILLAGE OAKS GLENDALE
EMERITUS CORPORATION DBA VILLAGE OAKS MESA
ENCANTO HOUSE
ENCANTO PALMS ASSISTED LIVING
ENCORE SENIOR VILLAGE AT PEORIA

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
ENCORE SENIOR VILLAGE PARADISE VALLEY
ESTACIO, ERMINA AFC HOME
ESTERA MARIA VIDREAN, DBA EMV ASSISTED LIVING HOME
EUREKA IMPERIAL RESIDENCE
EVERLASTING SERVICES
FAMILY CARE HOME INC HOUSE OF TREASURES
FAMILY HOME CARE
FERSETA, MARIA AFC HOME
FIRST WATCH MINISTRIES HOUSE OF HELPS
FISHER FAMILY HOME
FOGAL HOUSE
FOGAL HOUSE
FRIENDLY HOUSE
FRIENDSHIP MANOR I
FRIER HOUSE
FSL PATHWAYS CABOT HOUSE
FSL PATHWAYS HEARN HOUSE
FSL PATHWAYS HEARN HOUSE
FSL PATHWAYS INC (HAYWARD HOUSE)
FSL PATHWAYS WATSON HOUSE
FUGATT, EVA AFC HOME
GABRIELS HOME CARE
GARDEN HOUSE
GAYLES MANOR
GILBERT HOUSE
GLENCROFT TOWERS I
GLORIANNE ADULT CARE HOME
GOLDEN DAYS ACH
GOLDEN YEARS AT OCOTILLO
GOMEZ, BARRY AFC HOME
GONZAGA, HILDELITA AFC HOME
GRACE ASSISTED LIVING
GRAHAM, RUBY AFC HOME

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
GREEN GARDENER
GREENFIELDS ASSISTED LIVING
GRODZICKI, MARK AFC HOME
GROVERS TERRACE
GUARDIAN ANGEL
HANDS OF CARE ALH
HARMONT HOUSE
HARMONY FOUNTAIN CARE HOME
HARMONY PALM CARE HOME
HARVARD VILLA
HAWTHORNE, LOUISE AFC HOME
HAYWARD RESIDENTIAL
HEART TO HEART ACH
HELENS ADULT CARE HOME
HELENS CHRISTIAN HOME
HELLENS ADULT CARE HOME
HELPING HAND ASSISTED LIVING
HERITAGE CARE HOME LLC
HILL CREST
HILLCREST ASSISTED LIVING
HOLLIE, JULIA AFC HOME
HOSTIUC, CARMEN AFC HOME
HRENIUC, IRINA AFC HOME
HUGER MERCY LIVING CENTER
IGNA, IOSIF AFC HOME
ILONAS FAMILY HOME
IMMANUEL MANOR GARDENS
INN AT THE AMETHYST ASSISTED LIVING
INSPIRATIONS GROUP HOME LLC
IVY HOUSE
JENSEN HOUSE
JO LEX AT OBISPO
JOHNSON, SALLY AFC HOME

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
JOLLY FAMILY CARE
JONES FAMILY CARE HOME
JUST A TOUCH OF TENDER AIDE
KELLY, ANN AFC HOME
KIERLAND ASSISTED LIVING HOME LLC
KIVEL MANOR ASSISTED LIVING CENTER
KYLA'S HOME 2
LA NINA ADULT CARE HOME
LAS FUENTES ASSISTED LIVING
LEGACY VILLAGE AT EAST MESA
LEISURE LIVING FOR THE ELDERLY DBA COMFORT LIVING HOME
LENDING HAND ADULT CARE HOME (FORMERLY MAYFAIR)
LIANNS HOMES #2
LIANNS HOMES #3
LIANNS HOMES #4
LIANNS HOMES INC
LIBERTY MANOR RESIDENCY INC
LIBERTY MANOR RESIDENCY INC
LONE CACTUS HOUSE
LOVING CARE ASSISTED LIVING
LOVING KIND CARE HOME TOO
LUPEA, ADELA AFC HOME
MABLE BEEBE ASSISTED LIVING
MALLORY, JOYCE AFC HOME
MARCO POLO HOUSE
MARCOS AND SECILIA RAMON HOME CARE
MARIAS ADULT CARE HOME
MARTA, MARIA AFC HOME
MARTHAS ASSISTED LIVING
MARYLAND GARDENS ALC
MASLIKOWSKI, KAZIMIERA AFC HOME
MAYS HAVEN
MEADOWBROOK HOUSE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
MERCYS CARE HOME
MEREWAY MANOR ADULT CARE HOME
MESA CHRISTIAN RESIDENTIAL CARE CENTER
MESA, ROSE AFC HOME
MICHELLE ADULT ASSISTED LIVING, LLC
MICLEA, ALEXANDRA AFC HOME
MILLER, DAISY AFC HOME
MIMOSA SPRINGS THE PLAZA
MONDELL HOUSE
MORNING GLORY ADULT CARE HOME
MY HOME CARE ADULT ASSISTED LIVING FACILITY LLC
MY NEW HOME
NEW REFLECTIONS ADULT CARE HOME
NORTH CANYON ADULT CARE HOME
NORTH STAR CARE HOME
OANCEA, MARIN AFC HOME
O Briens Care Home
OLAR, ANA AFC HOME
OLARI, STANA AFC HOME
OLNEY, DAN AFC HOME
ONE ON ONE ACH
ONIGA, PAULINA AFC HOME
ORCHARD LANE HOUSE
ORCHID RESIDENTIAL CARE HOME
ORION HOMES LLC
ORTIZ SUNNYSIDE ASSISTED LIVING LLC
PACURAR, MERI AFC HOME
PALM HOUSE I PLC
PECK HOUSE
PEPPERTREE SQUARE ASSISTED LIVING
PERSON TO PERSON ASSISTED
PHILLIPS HOUSE
PLATA HOUSE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
PLATINUM ASSIT CARE-WILLO
PLEASANT STAY
POENARU, MARIA AFC HOME
POTTER HOUSE
PROGRESSIVE FAMILY HOME
QUALITY SENIOR CARE HOME
REANNAS TOO ASSISTED LIVING HOME
REFLECTION BAY ASSISTED LIVING AND MEMORY CARE
REJOICE GROUP HOME
RODY'S ADULT CARE HOME
ROSE COURT SENIOR LIVING
ROSE GARDEN
ROSEDALE GARDENS VENTURES, LLC
ROSEWOOD CARE HOME
ROYAL ASSISTED LIVING CENTER
SAN JUDAS GROUP HOME
SARAHS HOUSE
SCOTTSDALE ADULT CARE HOME
SCOTTSDALE ASSISTED LIVIN
SHEPHERD, DEBRA AFC HOME
SHERIDAN GARDEN ASSISTED LIVING 1
SHERIDAN GARDEN ASSISTED LIVING 2
SHERIDAN GARDEN ASSISTED LIVING 3
SHIV ADULT CARE HOME
SIENNA POINT ADULT CARE HOME LLC
SIERRA VISTA HOUSE
SINAI ASSISTED LIVING HOME LLC
SIPOS, ANA AFC HOME
SOLTERRA SENIOR LIVING
SONORAN SKY COMMUNITY SRV
SPECIALIZED HOME CARE - DES MOINES
SPRING VALLEY ASSISTED LI
SPRINGDALE VILLAGE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
ST MICHAELS MANOR
SULLIVAN, MIKE AFC HOME
SUN CREEK
SUNNYHILL ACH INC
SUNNYSIDE CARE HOME
SUNRISE ADULT CARE HOME
SUNRISE ADULT CARE HOME
SUNRISE ADULT CARE HOME NO 2
SUNRISE HOME FACILITY
SUNSET ADULT FAMILY HOME
SUNSET HOUSE
SUNSET VISTA
SWEET HOME ADULT CARE HOME
TATUM QUALITY CARE ASSISTED LIVING HOME
TENDER LOVING CARE HOME I
THE ALEXA HOME LLC
THE BRADLEY HOME
THE LODGE AT 14TH STREET
THE LOVING KIND CARE HOME I
THE MIRACLE CASTLE HOME CARE
THE NEW FOUNDATION
THE NEXT GENESIS INC
THE PARK AT 7TH AVENUE
THE SIERRAS ASSISTED LIV
THE TELFORD HOUSE
THE TELFORD HOUSE
TLC ROSEWOOD MANOR
TRETHEWAY HOUSE
TRETHEWAY HOUSE
TRIF, LIDIA AFC HOME
TROJANEK, SOPHIE AFC HOME
TRUFIN, MARIANA AFC HOME
TWILIGHT HAVEN ASSISTED LIVING HOME

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b> <i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
TWILIGHT HAVEN DIRECTED CARE LEVEL
VALLEY OF THE SUN ASSISTED LIVING FACILITY
VEMA CORP
VEMA CORP 41ST DRIVE
VEMA CORP 42ND DRIVE
VEMA CORP CHOLLA HOME
VEMA CORP SIERRA
VEMA CORP VILLA ENCANTO 1
VEMA CORP VILLA ENCANTO 2
VENTANA LAKES ASSISTED LIVING HOME
VENTANA WINDS ASSISTED LIVING LLC
VENUS ASSISTED LIVING HOME
VERONICAS ELDERLY CARE HOME
VICKYS LOVING HOME
VISION GROUP HOME
WARM WELCOME
WERNER, DONEITTA AFC HOME
WESTOWN ACH
WHISPERING WATERS ASSIST
YOUNG LIFE AL 3 TBI
YOUNG LIFE ASSISTED LIVING
ZABLOCKA, SLAVA AFC HOME
ZAHRA MUTWOL DBA BARAKA HOUSE

<b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b>
<i>(sorted alphabetically by name; duplications are the result of multiple locations)</i>
A DESERT CASITA ALH
A DESERT VILLITA
A LA CARE HOME LLC
ACL/AK ADULT CARE HOMES
ALL COMFORTS OF HOME
AMIE ROSE ALH LLC DBA INFINITY ASSISTED LIVING
AMOR DE MADRE ADULT CARE HOME
AMORE ASSISTED LIVING/ SUNNY HILLS ADULT CARE HOME
AMOROSA ASSISTED LIVING
ANGELAS ASSISTED LIVING II, LLC
ANNREL INC DBA CASA JORGE
ARANDIA, PATSY
ASTERION ACRES LLC
ASTERION ACRES LLC - 7008
AUTUMN HOUSE ADULT CARE
BETANIA CARE HOME
BLUEFIELD ALH
CANYON HEIGHTS ACH
CARE HAVEN
CARE HAVEN ACH
CARESTONE AT RIVER CENTRE
CARIVACA ALH
CASA BLANCA
CASA DE DIOS, INC.
CASA DE PAZ
CASA ESPERANZA DBA VICTOR LOPEZ
CASA THERESITA III
CASAS ADOBES ASSIST LVG
CECEN, MARGARITA
COLEMAN, JANET C

<p><b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b></p> <p><i>(sorted alphabetically by name; duplications are the result of multiple locations)</i></p>
COMFORTABLE CARE HOME
CROSSROADS ADULT CARE HOME
CROSSROADS ADULT CARE HOME II
DAISY BLOOMS CARE HOME
DESERT VILLA HOME, INC
DEVON GABLES HEALTH CARE
ELDER CARE AND MORE
ELDER CARE AND MORE II
ELDERHAVEN
EMERITUS AT CATALINA FOOTHILLS (THE COURT AT TUCSON)
EMERITUS AT PATANO
EMMANUEL CARE HOME
EMMANUEL CARE HOME II
EMMANUEL CARE HOME III
ESPINOZA, GLORIA
FIVE STAR ADULT CARE HOME LLC
FRANCES ADULT CARE HOME I
FRANCES ADULT CARE HOME II
FRAUSTO JR., MARTIN D
FROM-R-HEARTS LLC
GOLDEN OASIS
HEART & SOUL ACH LLC
HEARTHSTONE MANOR
HEATHERWOOD
HEAVEN CAN WAIT
HEAVENLY ACRES ASST
HERITAGE MANOR AT LAGO DEL ORO LLC
HIGHLAND HILLS ACH LLC
HORIZON ACRES ALH
HOUSE OF PRAYER
HUMMINGBIRD MANOR I

<p><b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b></p> <p><i>(sorted alphabetically by name; duplications are the result of multiple locations)</i></p>
HUMMINGBIRD MANOR II
INTERMOUNTAIN CENTER FOR HUMAN DEVELOPMENT
KLEIN HOME CARE
LA PALOMA HOME FOR THE AGING
LA ROSA HEALTHCARE CENTER AT SANTA CATALINA VILLAS
LEAN ON ME ADULT CARE HOME/ALL ABOUT YOU ADULT CARE
LOVE CARE CO.
LUNA, RAMONA
M&S ASSISTED LIVING HOME
MANANTIAL DE VIDA
MARSHALL HOME FOR MEN
MARYS PEACE OF MIND ALH
MENDOZA, MAGDALENA
MIRANDA, MARIA DBA PRINCESS ADULT CARE HOME
MONTE VISTA PLACE
NANS HACIENDA
NUESTRA CASA CARE HOME INC.
NW ASSISTED LIVING 1
OH-BE-JOYFUL
OMEGA ASSISTED LIVING
PELION ADULT CARE HOME
PROVIDENCE HOME LLC
QUEEN PALMS ADULT CARE HOME
ROSAS LITTLE HOUSE ALH
ROSE OF SHARON FAMILY HOME
SAGUARO ACRES ASSISTED LI
SAGUARO ELDER CARE
SAGUARO HORIZONS ADULT CARE

<p><b>GSA 52: ASSISTED RESIDENTIAL FACILITY PROVIDERS</b></p> <p><i>(sorted alphabetically by name; duplications are the result of multiple locations)</i></p>
SAKUTAS ENTERPRISES, INC DBA FAITHFUL HEART ALH
SAKUTAS LOVING HEART AL
SAKUTAS YOUNG AT HEART
SEARLES CARE HOME
SHADY LANE LIVING
SIERRA ADULT CARE LLC
SIERRA MADRE ADULT CARE HOME
SILVERBELL MANOR ASSISTED LIVING HOME
SIMANCAS ALH
SOUTHERN ARIZONA MENTAL HEALTH CORP (SAMHC)
SPRING DAYS AKA CASA DE ROSE ACH
SUGARS II ASSISTED LIVING HOME
TANQUE VERDE ALH III
THE GOLDEN GIRLS ACH, LLC
THE OASIS AT EL CORRAL
THE ROSE
THE RUBIN COMMUNITY FOR SENIOR LIVING
THE VILLAS AT KING ROAD
TITAS HAPPY ASSISTED LIVING HOME, LLC
TITAS HAPPY ASSISTED LIVING HOME, LLC
VILLA DE AMISTAD
VIVIANAS HOME CARE
WHISPERING HILLS CARE HOME - CHAPALA
WHISPERING HILLS CARE HOME - WHISPERING HILLS
WHITE DOVE ADULT HOME CARE

<b>GSA 52: HCBS Providers</b> <b>(sorted alphabetically by name; duplications are the result of multiple locations)</b>
ABIL ARIZONA BRIDGE TO INDEPENDENT LIVING
ACCENTCARE AT HOME INC
ACUMEN FISCAL AGENT, LLC
ALL AT HOME HEALTH CARE
ALL N ONE HOME HEALTH AGENCY LLC
ALL VALLEY HOME HEALTH CARE AND NURSING INC
AREA AGENCY AGING ARBOR ROSE
AREA AGENCY AGING EAST VALLEY
AREA AGENCY AGING GLENDALE
AREA AGENCY AGING JC LINCOLN
AREA AGENCY AGING MARYS PLACE
AREA AGENCY AGING PEORIA
AREA AGENCY AGING REGION ONE
AREA AGENCY AGING SIRRINE ADOBE
AREA AGENCY AGING SIRRINE MCDOWELL
AREA AGENCY AGING ST CLE
AREA AGENCY AGING SUN CITY WEST
AREA AGENCY AGING TEMPE
AREA AGENCY ON AGING PHOENIX ADULT DAY SERVICES
ARISE INC
ATTENTIVE HOME HEALTH
BANNER GARDENS HOSPICE HOUSE
BANNER HOME CARE
BANNER HOME CARE
BANNER HOME CARE HOSPICE
BARRIER FREE AMERICA
BAYADA NURSES INC
CARE CORNER PERSONAL SERVICES INC
COMFORT KEEPERS CHANDLER
COMFORT KEEPERS FOUNTAIN HILLS
COMFORT KEEPERS NORTHWEST

<b>GSA 52: HCBS Providers</b> <b>(sorted alphabetically by name; duplications are the result of multiple locations)</b>
COMMUNITY OF HELPING ANGELS INC
COMPLETE COMFORT CARE
CONCEPTS IN CARE
CYPRESS STAFFING SERVICES
FELICITY HEALTH CARE
FELICITY HOME CARE LLC
FOCUS CARE OF ARIZONA LLC
FOX, ANGELA M
FSL PROGRAMS HOME CARE
FSL PROGRAMS HOME HEALTH
FSL PROGRAMS HOME MODIFICATIONS
GOOD NEIGHBOR ASSISTED LIVING SERVICES
HAGGAI HEALTHCARE CORP
HERITAGE HOME HEALTHCARE
HERITAGE HOME HEALTHCARE
HOME INSTEAD SENIOR CARE
HOME INSTEAD SENIOR CARE GILBERT
HOME INSTEAD SENIOR CARE GREENWAY
HOSPICE FAMILY CARE - MESA
HOSPICE INSPIRIS
HOSPICE OF ARIZONA
HOSPICE OF THE VALLEY
INNOVATIVE HOME HEALTH
INSPIRE CO-OP
INSTANT CARE OF ARIZONA
LIFE LINE
LOVING CARE AGENCY
MAXICARE HOME HEALTH INC
MAXIM HEALTHCARE SERVICES

<b>GSA 52: HCBS Providers</b> <b>(sorted alphabetically by name; duplications are the result of multiple locations)</b>
MAXIM HEALTHCARE SERVICES
MD HOME ASSIST
MD HOME HEALTH AND STAFFING
MGA HOME HEALTH
NURSES PLUS HEALTHCARE, LLC
NURSING SOLUTIONS
ODYSSEY HEALTHCARE OF PHOENIX
OVATIONS HOSPICE INC
PHOENIX HOME HEALTH NURSING SERVICES
PROFESSIONAL HEALTH CONSULTANTS
RELIABLE CONSTRUCTION
RESCARE HOMECARE
RIGHT AT HOME
RIGHT AT HOME
SELECTIVE HEALTHCARE INC PRIMARY FUNDING CORP
SERENITY HOSPICE & PALLIATIVE CARE
SOARING EAGLES HOME CARE
SUNFLOWER ADULT DAY CARE
SUPREME HOME CARE
SYNERGY HOME CARE
SYNERGY HOME CARE
SYNERGY HOME CARE - PHOENIX
SYNERGY HOME CARE OF SCOTTSDALE
THRASHER, TAMIS J
THRASHER, TAMIS J
TLC SERVICE
UNIVERSAL IN HOME SUPPORTIVE SERVICES INC
UPWARD FOUNDATION
ZION HOME HEALTH CARE AGENCY

<b>GSA 50: HCBS Providers</b> <b>(sorted alphabetically by name; duplications are</b> <b>the result of multiple locations)</b>
ACCESSIBLE HOME REMODELING
ASCENSION IN HOME MEDICAL NP'S GROUP, INC
AZ BUILDERS AND MAINTENANCE COMPANY INC.
BAYADA NURSES INC
BAYADA NURSES INC
CARONDELET HOSPICE AND PALLIATIVE CARE
CATHOLIC COMMUNITY SERVICES OF SO. AZ INC.
CATHOLIC COMMUNITY SERVICES OF SO. AZ INC. DBA CATHOLIC SOCIAL SERVICES
DEPENDABLE HEALTH CARE
DEPENDABLE HOME HEALTH INC
DEPENDABLE NURSES
DESERT HORIZONS COMMUNITIES
EASTER SEALS BLAKE FOUNDATION
FELICITY HEALTH CARE
HANDMAKER JEWISH SERVICES FOR THE AGING
HOSPICE FAMILY CARE - TUCSON
JMT CONSTRUCTION
LIFE LINE
LUTHERAN SOCIAL SERVICES OF THE SOUTHWEST
LUTHERAN SOCIAL SERVICES OF THE SOUTHWEST
MAXIM HEALTHCARE SERVICES
MOBILE MEALS OF TUCSON
ODYSSEY HEALTHCARE OF TUCSON
PCOA FOR ALL, INC.
SOREO
SOREO
SOREO IN HOME SUPPORT SERVICES LLC
TAYLOR, WILLIAM

## **Special Populations**

At MCP, we pay special attention to developing and contracting with providers who offer *specialized* services targeting the unique needs of special needs members. Often the CMO and other medical directors, based upon their experience with the medical community, have significant involvement in the identification and recruitment of providers to meet these specialized needs. An example is the El Rio Infectious Disease Providers in Pima County, who treat members with immune-deficiency disease. The expertise of these specialized providers allow these medically complex MCP members to receive highly specialized care that best meets their complex medical needs.

In some cases, members may present with needs that have not yet been defined as a network need. In these cases, MCP works diligently with the medical community, or HCBS provider to determine how to best meet these specialized medical/behavioral or specialized needs.

We support the delivery of care to special needs members by assigning highly skilled CMs with the appropriate training and educational background (including specialized pediatric CMs for our ALTCS children). Additionally, we provide training to all contracted providers regarding the complex nature of our special needs populations. Our members with special needs may also be assigned to a specialist, rather than a PCP, if necessary, to facilitate ongoing care.

## **Medical Homes**

Due to our strong commitment to patient center medical homes, MCP launched a patient centered medical home (PCMH) pilot for our ALTCS members assigned to St. Joseph's Family Practice Clinic in Maricopa County. The PCMH concept is an exciting and promising approach for providing highly coordinated and responsive care to ALTCS members. MCP has identified ten additional PCMH locations in Maricopa and Pima Counties during CY2011. Because the operational changes to support a medical home increases costs to PCMH providers, MCP is exploring different payment models that reward primary care physicians appropriately. MCP also plans to offer increased CM support to practices who offer PCMH care to our membership.

In collaboration with the Carondelet Medical Group and the University of Arizona in Pima County, we will launch a diabetes management program in CY2011 that focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and tele-monitoring technology for at risk members.

MCP and its sponsor system CHW, have been selected as West Wireless Health Institute's healthcare partner, and we are actively involved in a project synergistically building upon a medical home pilot serving members with CHF. The program supports the use of mobile technology devices which allow care teams to track accurate on-going trend data, giving them easy access to vital patient information and enabling better informed treatment decisions. Remote patient monitoring enables physicians and care providers to more accurately assess the trends in a particular individual's personal lifestyle, empowering them to more quickly and easily intervene as needed. Rather than wait for the patient's next routine visit, care providers can address potential health problems early on, often reducing the number of costly, unnecessary emergency room visits. Personal connected healthcare also offers a viable alternative to institutional living, helping to improve the quality of life for the aging population. It also allows improved efficiency of, and access to, healthcare by augmenting face-to-face encounters with providers – which is particularly important for those individuals living in rural areas or those for whom frequent office visits are more difficult.

## **Homeless Members**

MCP values the importance of serving the homeless population. Providing health care for this segment of members is equally challenging and rewarding. We contract with several providers that have expertise in caring for the needs of homeless members, as indicated below.

MCP is contracted with the following providers at AHCCCS fee for Service Rates for Primary Care services as they have developed programs geared towards providing services to homeless members:

- Healthcare for the Homeless Maricopa County
- Homeless Dental Services Maricopa County
- John C. Lincoln Health Center Maricopa County
- El Rio Health Center Pima County
- St. Elizabeth's Health Center Pima County

The type of service differs by provider. In Maricopa County, some of the providers actually provide services on the site of one of the larger homeless shelters. These provider contracts stipulate that only those members that request a homeless clinic as a PCP may be assigned to them. Members that are assigned to a homeless clinic may be referred out-of-network for needed specialty services. MCP makes resources available to assist homeless clinics with administrative issues such as obtaining Prior Authorization, and resolving claims issues through our 24/7 customer service line, website, and through our provider and member services staff. MCP takes an active role and attends collaborative meetings with the homeless clinics, when AHCCCS convenes. MCP works diligently with these homeless clinics to resolve administrative issues and perceived barriers to serving the homeless members.

MCP contracts with community based health care organizations, primarily the FQHCs and RHCs that provide services to Medicaid eligible individuals and others who require financial assistance to receive health care services. These clinics have served as the traditional safety net provider for the homeless population.

Carondelet Health Network (CHN) and MCP are participating in an innovative collaboration to serve homeless members. The City of Tucson and Pima County Task Force demonstrated that coordinated care is critical to maximize the efforts of the diverse agencies serving the local homeless population. MCP along with MCP's sister agency Carondelet Health Network took the opportunity to play a significant role in addressing homelessness and supporting the community's efforts to improve the stability, capacity and wellbeing of homeless individuals in developing the Southern Arizona Health Village for the Homeless. In coordination with local organizations, Carondelet Health Network worked with the Carondelet Foundation, the fundraising arm for Carondelet Health Network, to secure a financial commitment of \$2 million dollars, payable at \$400,000 a year over the next five years from an anonymous donor. This partnership has developed five distinct objectives with measurable outcomes:

1) *To establish a consortium of partners* – These include the Roman Catholic Diocese of Tucson, El Rio Community Health Center, St. Elizabeth's Health Center for the uninsured, Primavera Foundation for the Homeless, Pima Community Access Program (PCAP) for health coverage assistance, Pima County Health Department, Interfaith Coalition for the Homeless, Salvation Army, Dependable Home Health Services, Veterans Affairs and Tucson Planning Council for the Homeless. Partners were identified based on their level of services and commitment to enhancing the health and well-being of the homeless population.

2) *To create the continuum of care* – These different partners helped design a seamless continuum of care that will increase the number of health care service visits for the homeless in an appropriate setting. The design is based on the Chronic Care Model (Wagner, EH, Effective Clinical Practice 1998; 1:2-4) to ensure the best possible functional and clinical outcomes, as well as to encompass a vast array of services that are primarily mobile because of the target population's limited access to resources and transportation.

3) *To increase the number of health care service visits for the homeless* – The program's flagship effort, which launched in early 2010, is the Van of Hope, a 38-foot Bounder RV equipped to provide mobile medical services at sites frequented by the homeless in our community. These sites include shelters, churches and other public areas where the homeless congregate. A nurse practitioner, community health outreach worker and clerical assistant staff the van. Together, they provide health assessments, treatment, medications, case management and community referrals. The van is equipped with telemedicine technology including an exam camera, ensuring that services such as tele-dermatology, tele-wound care and other consultations can be offered with “real time” or “store and forward” capability.

In addition, this collaborative effort designated certain acute and extended care beds in hospitals community-wide; case management and social service outreach to homeless children through the school systems; behavioral health screenings and connection to Carondelet's behavioral health program, which offers 24-hour crisis assessment; and specialized health ministry training to churches and faith-based communities who already make a concerted effort to help the homeless with social services.

4) *Improve Outcomes, Save Costs and Evaluate* – Improving clinical outcomes and reducing inappropriate use of emergency department resources are key measures to addressing the adverse effects of the homeless on the health care system. Significant costs are attributed to inappropriate emergency and inpatient admissions for conditions that are often preventable, but highly acute due to lack of primary care.

5) *Cost Savings* – The program has resulted in 71 percent annual savings for Carondelet Health Network in avoidable emergency department and inpatient admissions at Carondelet St. Mary's Hospital. These significant savings in cost avoidance will help Carondelet Health Network continually reinvest, grow and sustain the Southern Arizona Health Village for the Homeless program.

## **FQHCs**

MCP contracts with several FQHCs at rates that are similar to those providers that provide similar services. The following is a listing of the FQHCs which MCP contracts to meet the needs of members who reside in outlying areas.

- Adelante Healthcare, Inc.
- Canyonlands Community Health Care
- Chiricahua Community Health Centers, Inc.
- Community Health Centers of West Yavapai
- Desert Senita Community Health Center
- El Rio Health Center
- Marana Health Center, Inc.
- Maricopa County Health Care for the Homeless
- Maricopa Integrated Health Systems Clinics (FQHC look-alike)
- Mariposa Community Health Center, Inc.
- Mountain Park Health Center
- Native Health
- North Country Community Health Center
- Sun Life Family Health Center
- United Community Health Center, Inc.
- Wesley Community Center

- United Community Health Center, Inc.
- Wesley Community Center
- Community Hospital Clinic at Wickenburg Community Hospital
- Copper Queen Community Hospital
- La Paz Regional Hospital (d/b/a La Paz Medical Services - Quartzsite and Tri-Valley Medical Center)
- Northern Cochise Community Hospital, Inc.

### **Arizona Early Intervention Program**

MCP identifies children enrolled in the AzEIP program from the daily enrollment file. The AzEIP Coordinator refers children enrolled in both MCP and the AzEIP program to the MCP Special Needs Program in the QM Department for coordination of health care services to be provided through us. We contact the assigned PCP to ascertain the level of assistance, if any, required to manage the member's care. If necessary, the member is enrolled in one of our case management programs to assist with coordination activities as required.

### **Members in Border Communities**

MCP makes care accessible by contracting with providers in bordering areas. In Santa Cruz County we are contracted with Mariposa Community Health Center (MCHC), which participates in El Rio Health Center's Border Community HIV program. Through our collaboration with El Rio Health Center, we support this program in rural counties. MCP's arrangement with Desert Senita assists us to meet the needs of those members in Ajo, Arizona.

CHN's management arrangement with Sierra Vista Regional Health Center brings shared complementary visions, missions, values, and goals. This arrangement brings a strong healthcare delivery system to MCP membership residing in the Sierra Vista communities. There are many benefits to this agreement some of them include:

- Enhanced physician recruiting
- Ease of patient transfer and admissions to Carondelet hospitals
- Enhanced opportunities for the residency program
- Opportunities to enhance existing as well as to develop new clinical services for the community
- Access to operational and clinical best practices

### **Assigning Members with Special Health Care Needs to Specialists**

It is our policy to offer all members freedom of choice within the network in selecting a PCP. We assist members with selecting a PCP upon enrollment and at any time that a member requests a change. When needed, members can be assigned directly to a specialist provider for ongoing primary care, and members may make these requests. In these instances, our medical management staff coordinates with the member's current PCP and the specialist to determine appropriateness of assignment. We approve appropriate requests based on disease state or complex, serious, or chronic medical condition to facilitate effective and convenient medical services.

Occasionally, we identify members with special healthcare needs through our outreach efforts such as our AHCCCS Performance Measures, Provider Assistance Program (provider request), case and disease management, and other programs designed to reach out to members, or through our case management program. In these situations, we work with members and their current PCP, and the CM to

discuss the potential and appropriateness of reassignment. Examples of members who may be assigned to a specialist include those with chronic asthma, end stage renal disease, cancer, HIV/AIDS, chronic heart disease, and members with diabetes. Pregnant members may also select or be assigned to a primary care physician specializing in obstetrics. Lastly, homeless members may select a homeless clinic as their PCP.

### **Strategies to Reduce Unnecessary Emergency Department Utilization**

MCP utilizes a number of strategies to reduce members' unnecessary use of the emergency department (ER). These strategies include requiring after hours and urgent care appointment availability in provider contracts, and monitoring providers to validate compliance.

MCP has implemented medical management programs to reduce avoidable ER visits. Members who frequently used the ER are reviewed to determine opportunities to assist them to meet their needs through their assigned PCP or referral specialists. MCP Case management staff work diligently with these members to educate them, and assist them to identify more effective opportunities to meet their needs. Also, in efforts to reduce unnecessary use of the ER, MCP worked collaboratively with some of our larger provider practices to institute evening and Saturday hours in efforts to reduce unnecessary emergency department utilization. The PCMH pilots provide case management support and financial incentives to practices who offer after-hours care in lieu of referrals to emergency rooms for non-emergent care. Our CCI program is intended to assist in identifying opportunities to reduce inappropriate ER use for our ALTCS members with behavioral needs.

MCP's provider contracts clearly stipulate accessibility requirements (in accordance with AHCCCS requirements) to promote physician visits rather than ER visits (i.e. after hours call availability or coverage, immediate appointment for emergent conditions, and same day appointments for members with urgent conditions). Our PSRs measure compliance with these requirements through onsite and telephone monitoring. In CY2010, compliance with accessibility standards was approximately 99 percent. The Network Management & Operations Team conducts a review of providers who do not meet accessibility standards and have high ER utilization for their assigned members. The review includes analysis of member grievance information related to accessibility for that provider in conjunction with accessibility audit results. We initiate corrective action plans with providers that do not meet accessibility standards, which may include closing their panels, visits by the medical director or PSR, and as a last resort, possible termination from the network.

MCP contracts with a large network of urgent care facilities that provide a cost effective alternative to the ER, allowing members to seek care for urgent health care conditions after core PCP office hours. We require via contract, that urgent care providers send medical records to the assigned PCP. We also stipulate this on our website. The PSRs measure compliance with this standard during annual site visits. MCP introduced a new partnership with NextCare Urgent Care facilities with the development of specialized programs. This partnership includes providing member education and re-direction of non-life threatening care to NextCare locations versus the Emergency Room. Educational materials are provided to assist with introducing the Urgent Care concept and lower cost alternatives.

MCP informs members about the availability of these options through the initial member packet, member handbook, member newsletters, website, member services representatives, and information provided by the member's CM. We describe when and how to seek care from a PCP compared to an urgent care center or ER. When members contact us, a member service's representative provides information to help them decide which treatment option best meet their needs. PSRs share information about the Plan's network of urgent care providers during site visits.

In addition, MCP has several medical management initiatives to identify and reduce unnecessary emergency department utilization targeted at both members and providers. Examples include:

- **Identifying and Coaching Members** – MCP uses the predictive modeling tool, Predictive Pathways® (PPM) to review members' utilization patterns including ER and pharmacy use. Experience has shown that patients with six or more ER visits in a 1-year period are more likely to use the ER out of habit rather than medical need. The PPM report tells us which members frequently use the ER, if the member's diagnosis is generally appropriate for ER care (e.g., Cancer and Pneumonia) or not (e.g. Cold, Rash, Anemia) and who does or does not receive disease management (DM) services.
- **Identifying and Coaching Physician Groups with High Panel Use of ER** – We conduct quarterly analysis of all PCPs that includes ER utilization in comparison to other PCPs in the same practice type. Our medical directors visit physicians that perform over two standard deviations above the average, discuss specific individual patients that may be over-utilizing and offer education on how to better direct patients to or from the ER in the future. We discuss ways to use after hours clinics, urgent care centers, better office scheduling for non-emergent care, and when it is best to use the ER.
- **24 Hour Behavioral Health Crisis Intervention** – MCP offers a 24/7-hour behavioral health crisis line, where our clinician verifies the member's safety and works to stabilize the situation and identify the appropriate care needs. We may refer the member to outpatient services or if warranted, facilitate immediate access to an emergency service provider. We evaluate members who present at the ER with behavioral health issues on site to identify admission needs or divert to a lower level of care. This moves these members through the ER more quickly and increases ER availability to other members in critical need.
- **Consultation and Clinical Intervention Team (CCI)** – MCP operates a collaborative program with CPSA to better meet the needs of behavioral health members; it is anticipated to assist MCP in decreasing unnecessary ER utilization. By conducting comprehensive assessments, functional analyses, behavioral plans, crisis plans and service plans that bridge member needs defined by both, their behavioral and health conditions, has proven successful in decreasing unnecessary Emergency Room utilization.

All of these measures assist MCP to identify avoidable/preventable ER utilization and to continually review these outcome measures for their effectiveness.

## SECTION 11 – ADEQUACY OF THE GEOGRAPHIC ACCESS TO TERTIARY HOSPITAL SERVICES

---

MCP has contracts with most of Arizona’s tertiary care hospitals<sup>1</sup> including:

- St Joseph’s Hospital and Medical Center
- Banner Good Samaritan Medical Center
- Maricopa Medical Center
- John C. Lincoln Hospital, and
- Tucson Medical Center

These hospitals are geographically accessible to members throughout metropolitan Phoenix and Tucson. For those members in outlying or rural areas where there is no tertiary hospital, we coordinate and facilitate the transfer of members needing tertiary hospital services to a hospital in one of the metropolitan areas. This is the established pattern of care in these areas and is the same level of service available to the general population. Members may be transported via contracted ground ambulance or air, based on their acuity.

In addition to these tertiary hospitals, we are able to meet the membership’s inpatient care needs through our robust and geographically accessible acute care hospital network of over 49 hospitals. Additionally, we provide appropriate professional support in these hospitals through our broad and diverse physician network, and through the use of the following strategies:

- **Residency Programs:** In order to further enhance members’ access to hospital services, as well as support the needs of the community, we currently contract with hospitals that support residency programs. We will continue to explore additional opportunities to contract with residency programs;
- **Hospitalists:** We utilize hospitalists stationed at the contracted hospitals throughout the network. Many PCPs have decreased or eliminated their hospital practices, and prefer to allow providers who specialize in inpatient care management to care for their patients. Our policies allow PCPs to either follow their own patients or refer to a contracted hospitalist group.

---

<sup>1</sup> MCP is using the following definition of tertiary care hospital – a hospital which “provides a full range of services across the continuum of care, including some of the most highly specialized services, - i.e., specialized services with the exception of organ transplantation, which is considered quaternary care and for which there is generally only one center for each type of organ transplantation in the entire system. Tertiary medical centers are generally affiliated with schools of medicine, participate in undergraduate and graduate medical education and serve as regional referral centers. Acute care medical centers generally offer primary care, general, and limited surgical and diagnostic capabilities. Acute hospitals refer complicated patients to the tertiary centers for further treatment or evaluations.” <http://1.va.gov/Visn8/cares/Overview/GAOquestions.rtf>

## SECTION 12 – ASSISTANCE PROVIDED TO PCP’S WHEN REFERRING TO SPECIALISTS

MCP providers are provided an extensive provider orientation before joining our network to promote informed decision-making. Our ALTCS PSRs facilitate an in-depth review of AHCCCS program standards, state and federal guidelines, laws and regulations, AHCCCS minimum subcontract provisions, the provider contract, the provider manual, utilization review programs (prior authorization, concurrent and retrospective review) formulary/preferred drug list, website and other pertinent materials. Providers receive information on MCP’s process for communicating changes regarding: 1) our contract with AHCCCS, 2) program standards, 3) laws and regulations, or 4) AHCCCS or other minimum subcontract provisions. 5) network specialists. We also educate PCP providers on their roles and responsibilities as a network provider for the ALTCS program including, but not limited to, the following:

- Understanding the guiding principles and ALTCS mission and values for serving members with long term care needs
- Coordinating and providing member-centered care to our members including initiating referrals for necessary specialty care, or behavioral health services
- Verifying our members receive the most appropriate level of care in the least restrictive setting consistent with personal health, safety, and cultural beliefs
- Maintaining the member’s medical record including documentation of all services provided and any referrals for specialty services

After joining the network, MCP supports our PCPs through a variety of mechanisms including but not limited to:

- Site Visits: regularly scheduled meetings and ad hoc visits to the provider office to facilitate ongoing training. MCP conducts site visits at a minimum of four times per year for PCPs.
- Provider Meetings: annual meetings with PCPs in various locations throughout our geographic service areas to discuss program requirements, changes to our organization, website updates, changes to or new program standards, changes in laws and regulations and changes in AHCCCS minimum subcontract or other subcontract provisions. Our ALTCS provider services representative also attends meetings held by associations (i.e. AHCA) where we have an opportunity to share information on these topics and answer questions.
- Provider Contracts and amendments contain information regarding program standards, laws, regulations, and subcontract requirements and are designed for administrative simplicity and contain language to assist PCPs when referring to a specialist.
- Specific Written Materials: MCP issues written materials, upon AHCCCS approval, and informs providers of a material change at least 30 days in advance. Our policy is to: 1) send the request to AHCCCS for approval of a material change in operations or the provider network, including draft notification to affected members and providers, at least 60 days prior to the expected implementation of the change; 2) send providers written notification that describes the change, timeline for implementation and impact on the provider (using certified mail when appropriate), 3) post the information on our website, 4) discuss the information during office visits or meetings, and 5) coordinate closely with AHCCCS to minimize the affect on members or providers. MCP notifies AHCCCS within one business day of any unexpected changes that would impair its provider network in accordance with [42 CFR 438.207(c)]. The

notification includes information about how the change will affect the delivery of covered services along with MCP's plans for maintaining the quality of member care if the change is likely to affect the delivery of covered services.

- Provider Manuals which meet the AHCCCS/ALTCS prescribed criteria are up to date, and are available via our website for ease of access and assists providers on how to refer to specialists. Providers may print a hard copy or save an electronic version on a CD. The provider manuals and their updates reflect current requirements and practices and serves as the provider's principal resource document. Provider services representatives review the manual during site visits and verify that providers received and understood the information.
  - Mailings are personalized letters disseminated to providers to inform them of network program modifications. It is our policy to send mailings containing contract updates or changes by certified mail, return receipt requested, thus allowing the mailing to be documented.
  - MCP Website includes current information, updates, and materials so that it is an up-to-date and a reliable source for providers to receive timely, complete, and accurate information, including information on referrals to specialists. Our website meets all AHCCCS/ALTCS requirements. Our providers use the website to access information on program standards, laws, regulations, and subcontractor requirements. Our website also includes an on-line provider directory and search function, which makes finding a participating specialist more convenient. Through MCP's secure provider portal, providers can search for a network specialist and request the referral on-line. Recent upgrades to the provider portal allow the practice to submit attachments to the Health Plan for ease of supplying necessary documentation for Medical Director Review. Once the referral has been approved, providers receive an e-mail supporting the approval.
  - Case Management: In the ALTCS program, or for more complex cases, MCP assigns a CM to provide additional assistance in managing the member's care. This CM may also be of assistance to the PCP when referring to a specialist. We also refer to the QM Special Needs Unit that helps PCP's coordinate services for members with complex medical and high risk conditions.
  - Customer Service line: is staffed 24/7 to assist PCPs. In addition on-line eligibility verification is easy to access 24/7.
  - Remit Messages: For nonmaterial changes in our policies or programs, we include a notification in the provider's claims remittance advice. Information added to the bottom of the remit is easily viewed by provider staff.
  - Medical Management: MCP Medical Management staff is always available to assist PCPs in specialty services referrals. Complex medical members often require complex medical discussion. The ALTCS medical director is available to discuss any case with Network PCPs.
- MCP PSR and all our staff work diligently and closely with our contracted PCPs. by training them on all of the options available to assist them when referring to a specialist.

## SECTION 13 – ANALYSIS OF APPOINTMENT AVAILABILITY SURVEYS

---

MCP consistently conducts audits of provider’s appointment availability.

### **Monitoring of Appointment Standards:**

MCP requires physicians to adhere to the following appointment standards:

- 1.) PCP’s appointment standards:
  - Routine appointments within twenty-one (21) days
  - Urgent Care appointments within two (2) days
  - Emergency appointments on the same day
- 2.) Obstetricians
  - First trimester appointments within fourteen (14) days of request
  - Second trimester appointments within seven (7) days of request
  - Third trimester appointments within three (3) days of request
  - Appointments for members/enrollees identified as “high risk” within three (3) days of the diagnosis of “high risk” or immediately in an emergency.
- 3.) Specialists appointment standards:
  - Routine appointments within forty-five (45) days
  - Urgent care appointments within three (3) days
  - Emergency appointments within twenty-four (24) hours
- 4.) Behavioral Health Appointments
  - Appointments within 24 hours of referral
  - Routine appointments within 30 days

MCP monitors compliance with accessibility and availability standards through various methods that may include, but are not limited to, site visits, telephone calls, live or automated surveys, provider attestations, review of member grievances, surveys of members who call MCP, mail surveys and results from other MCP programs. Any member complaints related to appointment availability are immediately escalated for Provider Services for research and resolution to address. Also, MCP considers the PCPs total panel size when evaluating the PCPs panel. For any PCP with greater than 1,800 members as reported by AHCCCS, additional monitoring may be implemented to ensure member accessibility.

If the results from the Provider Appointment Availability Reviews indicate non-compliance, additional follow up or monitoring occurs.

In addition to reviewing appointment availability for new and establish members for routine, urgent and emergent availability, MCP reviews the amount of time members must wait to be seen during a scheduled appointment to ensure providers have sufficient capacity and ensure compliance with the AHCCCS/ALTCS contract to meet our member needs. MCP has systems in place to monitor and ensure that member assignment to PCPs is accurate and up to date.

### **Frequency of Monitoring**

Monitoring occurs at least quarterly and may be intensified if outcomes are not aligned with established standards.

### **Assessment and Follow Up**

Providers who are compliant with accessibility and availability standards require no further action until the next assessment. Providers who are not compliant with accessibility and availability standards receive a follow-up visit or outreach telephone call from the PSR to further educate the provider on compliance requirements related to appointment availability and accessibility. The Network Consultant continues to monitor provider compliance each month for up to three (3) consecutive months. The member services department may also randomly survey assigned members to assess compliance. Providers may also be asked to sign an attestation to attest that they comply with standards or risk panel restrictions.

MCP requires a corrective action plan (CAP) from any provider who does not pass an accessibility audit. CAPs are due from the provider within 15 business days of the notification. If compliance is not evident after additional intervention, the CMO or other MCP Medical Director contacts the provider via a letter or telephone call to express concern and offer assistance or in special instances, to schedule a personal visit to provider to discuss the non-compliance.

### **Tracking & Reporting**

Results from the audit are documented in a newly developed database that allows for immediate (daily, weekly, monthly and quarterly) reporting. The database tracks audit results by provider as well as Provider Services staff to monitor and ensure audits are being completed in an appropriate fashion. Additionally, QNXT is used to call track by specific provider and cross reference with the stand alone database results. The audit results are summarized into the AHCCCS-required format. The AHCCCS report is submitted quarterly.

MCP submits quarterly reports to AHCCCS which include the attestation of the validity of the methodologies used, including the statistical significance of the results, a cover letter summarizing the data and an explanation of the trends. MCP meets the appointment standards in the GSA in the Maricopa, Pima and Santa Cruz Counties for all lines of business.

## SECTION 14 – METHODOLOGIES USED TO COLLECT AND ANALYZE MEMBER, PROVIDER & STAFF FEEDBACK ABOUT THE NETWORK DESIGN & PERFORMANCE

---

MCP embraces a continuous quality improvement philosophy and process that includes a multi-departmental, comprehensive approach to network design and performance. We recognize that member and provider feedback are key indicators of operational effectiveness in providing quality care to members, and maintain multiple opportunities for both members and providers to provide this information and to participate in system enhancements. MCP incorporates member and provider feedback into our network design and performance activities to drive operational changes that improve the quality of member care. All of these ongoing efforts provide MCP the opportunity to communicate with members and providers, identify network efficiencies and/or deficiencies, fill network gaps, improve standards and identify opportunities to ensure all covered services are provided to meet the specialized needs of our member populations.

**Member Feedback:** MCP understands that the most important information we can receive about our programs, services, and processes comes from our members. Because MCP also understands that it is not just the information that is important but what we do with it, we provide a number of vehicles for our members to provide us with their comments, opinions, requests, and complaints.

**General Member Calls & Inquiries:** Member Service employees often receive calls from members asking about network locations, specialist availability or other network related questions. MCP documents and tracks these calls in the call tracking systems, promptly resolving immediate concerns. Tracking and analyzing member inquiries allows the plan to identify potential network gaps

**Member Interaction with Case Manager:** MCP ALTCS case managers (CMs) receive feedback from members during day-to-day interactions. Our CMs act as member advocates and facilitate dissemination of member feedback regarding the network design and performance throughout MCP.

**Member Complaints Grievances:** MCP uses the results from the member complaint/grievance process to identify, assess, and address specific areas of members' concerns related to our administrative performance or the delivery of healthcare services, and providers that present as outliers compared to peers. This information serves to identify opportunities to initiate service improvement, network design and corrective action activities that assist in meeting MCP service standards and our ability to meet member needs.

**Member Satisfaction Surveys:** MCP conducts annual member satisfaction surveys, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for dual eligible members, including those served through ALTCS. MCP also participates in member surveys developed by AHCCCS in accordance with state or federal requirements, or conducted by a MCP approved vendor using nationally standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®) ambulatory survey items. Information gathered provides MCP opportunities to target areas for improvement.

**Transportation Surveys:** MCP's Member Services department conducts telephone surveys based on a statistically significant random sample of members who requested transportation services the previous day. The purposes of this survey is to: 1) survey members about their satisfaction with the quality and timeliness of transportation services; 2) verify that the member actually received the service, which assists in the identification of potential fraud; and 3) measure whether transportation providers are meeting the AHCCCS transportation time standards. The results of these surveys are incorporated into MCP's quality management processes to target system improvements.

**Member Advisory Council:** MCP promotes our Member Advisory Council (MAC), which meets quarterly and is comprised of acute (6) and ALTCS (6) members who represent the membership and counties served by MCP. The MAC holds quarterly meetings and members are actively involved in the review of key member materials, survey results, annual reports, quality improvement activities and in suggesting areas for improvement in service delivery and network design.

**Staff Feedback:** Staff from other departments receive member feedback through routine activities such as completing assessments, treatment planning, and responding to member requests for information. When feedback affecting network design or performance is obtained, staff are trained to present the specific information to the Provider Services team for further investigation.

The vice president of member service operations reporting to our Chief Operating Officer (COO) and in conjunction with our Chief Medical Officer (CMO) and our executive management team uses these member information sources to analyze, develop, and implement systematic change based on feedback from our members. Results of these activities are presented to the Quality Improvement Committee (QIC), chaired by the CMO or designee. This is a cross-functional committee that includes the following personnel: 1) COO; 2) Vice President (VP) of quality management (quality management coordinator); 3) Case Management Administrator/Manager; 4) director of integrated case management (physical and behavioral health); 5) VP of member services; 6) director of provider services; 7) dispute and appeal manager; 8) VP of utilization management (UM coordinator); 9) director of prevention and wellness (EPSDT coordinator); and 10) VP of health plan operations. MCP's QIC, based on trends, recommends strategies and interventions to the QM/UM Committee for review and approval as performance improvement projects in non-clinical activities.

### **Provider Feedback**

MCP takes input from our provider network seriously and uses provider feedback as indicators of our performance. Under the direction of our Chief Operating Officer (COO), MCP staff from various departments collects and uses provider feedback to identify opportunities to make process improvement changes. MCP gathers provider feedback information from various sources, including the following:

- **Provider Satisfaction** – MCP's Provider Services department conducts provider satisfaction surveys in coordination with Member Services, Provider Services, and Administration support staff. Practitioner and provider surveys address satisfaction with MCP's network, utilization management procedures (prior authorization, concurrent review) claims processing, and MCP's response to inquiries. Additionally, providers are asked to supply feedback regarding the Plan's fee schedules, website content and usability, prior authorization process and cultural competency.
- **Provider Assistance Program** – This key program is designed to identify potential barriers to a member receiving care, and assist providers with member education and outreach. This process facilitates communication between MCP and its providers and allows further opportunity to improve member care.
- **Joint Operating Committees** – Contracted providers participate in service-specific meetings to discuss operational issues impacting the network. MCP solicits provider feedback on issue resolution and provides education on system requirements.
- **Provider Turnover** – Provider Services staff receive information regarding potential and actual provider turnover to identify action items and potential process or network improvements opportunities.
- **Provider Complaints and Appeals** – MCP Provider Services' staff document grievances in our call tracking system, and refer them to other departments as appropriate. Various departments may receive provider complaints – including AHCCCS, Provider Services, Member Services, Medical Management, Quality Management, Utilization Management and the claims department. Staff members in

each department receive training on documenting and resolving such complaints as well as the process for responding to quality of care issues. MCP provider calls are acknowledged within three (3) business days of receipt with resolution communicated to the provider within thirty (30) business days of receipt. Appeals are monitored to identify trends and to identify improvement opportunities.

- **Ongoing Site Visits** – Provider services staff solicit feedback at regularly scheduled and ad hoc provider site visits. PSR conduct an initial orientation for new providers to the network and follow up with regularly scheduled site visits thereafter. PSRs conduct routine site visits with PCPs, Obstetricians, Dentists and Specialists. Network Account Managers meet at least monthly with hospital and ancillary providers through Joint Operating Committee meetings.
- **Provider Meetings** – MCP conducts separate group meetings with Providers in various locations throughout our geographic service areas. The primary purpose of these meetings is to update providers of changing program requirements, relationship building and improving two-way communications. Medical Directors, Network Account Managers and PSRs and Executive Management may attend these meetings. This includes outreach to high volume specialists,
- **Office Manager Meetings** – MCP conducts meetings for provider office managers throughout all our geographic service areas. Similar to the provider meetings, the purpose of these meetings is to discuss network design, program standards, changes in regulatory requirements and fee schedule updates. Network Account Managers and PSRs coordinate and attend the meetings, inviting additional attendees as appropriate.
- **Committee Participation** – Providers are encouraged to serve as active, regular participants on various MCP committees, including Quality Management/Utilization Management Committee, Pharmacy & Therapeutics Committee and the Credentialing Committee. Providers often offer valuable suggestions and network feedback during these meetings.
- **Provider Audits** – Conducted quarterly with provider offices; including follow up on any Corrective Action Plans (CAP) to ensure they are implemented and measure the outcome of the CAP.
- **System Reports** – Claims reports and other system reports are continuously reviewed to identify opportunities to improve member or provider satisfaction or increase network sufficiency.
- **Staff Feedback** – Other departments, such as Medical Management, Member Services and the Claims Department may participate in the process of identifying network enhancements, gaps and/or performance issues. The Network Strategy and Business Development Council reviews requests from various providers for participation in the network and identify providers and areas where further coverage would be advantageous for our members.
- **Internal monitoring** – Staff run and review reports continuously to ensure improvement opportunities are identified early and to ensure any identified cleanup efforts are adequately addressed. For example, providers who submit claims electronically are routinely evaluated to determine if they would benefit from EFT. If so, the opportunity is implemented and provider satisfaction increased.

By utilizing all of these mechanisms MCP has implemented the following positive actions affecting Network Design and/or Performance:

***MCP uses member feedback to improve transportation***

In CY10 MCP identified the need to improve member satisfaction with transportation services. As a result, MCP developed a special, proprietary tracking and reporting software program to allow for fast, on-line documentation of transportation requests and issues. This

electronic tool saves time and reduces staffing costs since transportation requests are sent electronically instead of by facsimile machine. Additionally, MCP added an additional taxi transportation provider to our network to offer members a choice between providers. This friendly competition helped to motivate transportation providers to offer improved service to enhance quality of care. These interventions resulted in a seven percent reduction in transportation complaints.

***MCP uses Member Advisory Council recommendations to improve member communication***

MCP incorporated recommendations from the MAC to improve its strategies for member communication. Their feedback resulted in improvements to the member handbook and disease management materials. In CY10, the MAC focused on ways to educate members on “self-advocacy” to promote positive health outcomes. MCP implemented their suggestion to develop a medical record/diary in order to facilitate appropriate and accurate information between members, providers, and MCP.

***MCP uses provider feedback to improve claims payment***

Through its routine review of provider grievances, MCP identified the need to improve communication with providers related to claims payment. In response, MCP developed a Health Plan Operations department, which is responsible for claims research and resolution; reviewing product requirements and system configurations; managing provider records and encounter files; and reporting. This has proven to be a stabilizing factor in maintaining a stable and flexible network.

***MCP Provider Communication Leads to Increased Provider Satisfaction – Low Turnover Rates***

MCP re-engineered the Provider Services department in CY2010 to provide additional provider services staff and a more organized focus on individual provider needs. Representatives keep in close telephonic contact with providers and conduct regular office visits. Representatives encourage providers to discuss issues of individual concern with the goal of resolving them as they occur. For example, Representatives work with providers immediately upon learning that a provider may want to terminate their contract and actively address complaints or inquiries from providers. Representatives conduct appointment availability audits during visits and provide real-time education to noncompliant providers. Since implementing this approach, MCP has experienced low rates of provider turnover (0% turnover due to dissatisfaction), provider complaints, and noncompliance with appointment availability standards. Our MCP provider satisfaction scores are high and outperform the benchmark score for other Medicaid plans. We anticipate further increases in provider satisfaction as we continue to make improvements.

As shown by the above, MCP takes the opportunity to develop desk top procedures, implement or modify policies and procedures and identify and implement improvement opportunities for members, and providers. The purpose of reviewing all feedback is to identify and prioritize areas for immediate action, develop actions for improvement, and monitor implementation. The Provider Services department prepares reports to identify trends from these sources of information and presents the findings and proposed intervention to the Strategy and Business Development Council. The Strategy and Business Development Council is responsible for approving work plans, making additional recommendations and tracking progress against goals. The Project Management area is supporting the development of tracking tools to monitor progress of each identified network issue.

SECTION 15 – LISTING OF NON-CERTIFIED HOME HEALTH AGENCIES USED OR ANTICIPATE  
BEING USED

---

***Non-Medicare Certified Home Health Agencies (HHA):***

MCP does not contract with any non-Medicare Certified Home Health Agencies (HHA).

## SECTION 16 – WORK FORCE DEVELOPMENT

---

MCP staff participates on the ALTCS Direct Care Workers Committee. As a result, MCP worked collaboratively with other AHCCCS/ALTCS providers to implement some positive changes to the regulations for direct care workers.

As of January 1, 2011 MCP amended all Direct Care Worker (DCW) contracts to include that all DCWs hired on or after January 1, 2011 are required to meet the new training and testing requirements before July 1, 2012. Contract language includes that all DCW hired on or before December 31, 2010 are not required to meet the training and testing requirements if they remain employed with the same provider agency. Further contract language states that all DCWs hired after July 1, 2012 are required to meet the established training and testing requirements before the provision of service to members.

MCP will assist its current contracted providers who provide attendant care, personal care and/or homemaker services to submit the AHCCCS required attestation statement to AHCCCS on or before October 1, 2011, establishing their approval as a DCW Training and Testing Program. For any new contracted providers, MCP will assist them in attesting their intent to become an approved DCW Training and Testing Program and will require that the provider establish a timeline for doing so, or their plan to train DCWs employed by their agency through another means (e.g. contract with another DCW Training and Testing Program). The completed attestation statements shall be maintained on file with AHCCCS.

In the Pima and Santa Cruz GSA, Dependable Nurses, a joint venture partner of Carondelet Health Network, has received AHCCCS approval of its Direct Care Worker Training and Testing Program. Dependable was one of the first providers in Arizona to receive this approval.

MCP has work with the Pima Council on Aging to include the Attendant Care Program in our Pima/Santa Cruz County Network. "PCOA for All" a new Pima County Program, is developing a new caregiver training program using the "Principles of Caregiving" as the curriculum which was developed by the Direct Caregiver Workforce Initiative. PCOA for ALL is also developing a continuing education program of six hours per year as required for all caregivers, based on the contents of the Core Curriculum. PCOA for ALL will implement the training component this year.

MCP sponsored the Caregivers Training Institute (CGTI) 10<sup>th</sup> Anniversary Luncheon, held on March 31, 2011 at the Double Tree Hotel in Tucson Arizona. MCP supported the awards celebration and educational mission of the CGTI. The Institute has established itself as a key instructional provider with an exceptional record of producing screened, trained and well-qualified health caregivers since 2001. Through this sponsorship more individuals will have the opportunity to become professional caregivers. The AHCCCS Marketing Committee approved MCP's participation in and sponsorship of this event.

## SECTION 17 – STRATEGIES MCP USES TO PROVIDE MEMBERS WITH “IN HOME” HCBS VS. ASSISTED LIVING OR SKILLED NURSING FACILITIES

---

The strategies MCP uses to provide members with “In Home” HCBS versus Assisted Living Facilities or Skilled Nursing Facilities is based on the foundation of MCP’s case management program. MCP’s Case management program effectively assesses each member and develops a holistic and member-centered care plan for each member. As a result of our case management program which focuses on keeping members in the least restrictive setting, three-quarters (75%) of our overall current membership are residing in the community. It is important to recognize that approximately 86 percent of these members are living in a private home.

At each case management review and assessment for the members living in the SNF – our MCP CM asks the member if they are happy with their current setting. If any member reports that they are placed in a setting that is not of their choice, MCP CMs work directly with those members to discharge them to their preferred, least restrictive setting, if medically appropriate. Our CMs explain the available array of HCBS services including Skilled Self-Directed Attendant Care, Spouse Attendant Care, Agency Attendant Care, Home Health Nursing, and Respite Care. For members in HCBS settings, the CM reassesses the member’s needs to determine if they are adequately met by the current care plan. The care plan is reevaluated and if necessary, a new care plan is developed to meet the member’s specific needs.

MCP is very successful in maintaining members in their own homes. We provide a full of array of critical service inclusive of bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar activities are monitored to identify, correct and track gaps in service. Network needs are continually reevaluated to ensure service gaps do not occur in these critical needs. This allows more members to reside in their own homes.

### ***Ball v Betlach***

In compliance with Orders by the District Court in *Ball v Betlach* the MCP takes its responsibility seriously to establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. “Critical services” is inclusive of tasks such as bathing, toileting, and dressing, feeding, and transferring to or from bed or wheelchair, and assistance with similar daily activities. MCP developed a provider network to ensure these gaps are minimized. In the unforeseen instances that the hours of scheduled service differ from the actual ability to delivered service from the scheduled provider, MCP has the ability to resolve this gap within two hours of the gap being reported by utilizing back up caregivers which are available on call. MCP reports any gaps to AHCCCS in accordance with AMPM Chapter 1600 and ACOM Gap in Services Policy, every November and May, regarding any trends and corrective actions, gaps in service, grievances related to service gaps and any other report as deemed necessary by AHCCCS. Reported gaps are tracked and trended to allow MCP to take steps to further mitigate any future gaps.

### **MCP LTC Non-Provision of Service (NPS) and Critical Services Gap Process *Informing Members***

The MCP Long Term Care (LTC) department has processes in place to identify, correct, and track gaps in service. At the initial intake assessment, and during care plan reviews, the LTC CM provides each member with a New Member Packet. Included in this packet are the following items:

- “Critical Services Gap Report” form

- “Important Member Rights Notice” letter, provided to MCP by AHCCCS.

The LTC CM reviews this information with our members and explains these forms to the member. Once the member fully understands their options, and these documents, they are requested to sign a form acknowledging they have received and understand this information. This acknowledgement form includes all the other items in the New Member packet and is maintained in the member’s LTC case management record. This intake method provides the member with both a written and verbal explanation of the member’s right to receive services as authorized, and the right to receive these critical services from a backup substitute caregiver within 2 hours of any reported gap.

If at the member’s intake assessment they are interested in one of the “critical services” identified by AHCCCS as being 1) attendant care, 2) personal care, 3) homemaker, or 4) respite, the CM takes the next step in completing the AHCCCS “Contingency Plan” form.

The first step in completing the Contingency Plan form is reviewing and explaining the four AHCCCS defined Member Service Preference Levels (MSPL) with the member/representative, and circling the MSPL selected by the member on the Contingency Plan. The MSPL options include 1) Need services within 2 hours, 2) Need services today, 3) Need services within 48 hours, or 4) Can wait until next scheduled visit. The CM also explains to the member/representative that the MSPL selected on the Contingency Plan form can be changed at any time, including at the time of the gap if one should occur; and the member initials the form acknowledging their understanding of this option.

The CM then completes the contact portion of the Contingency Plan with the member/representative, which includes the phone numbers of the following: 1) AHCCCS line, 2) MCP CM, 3) Provider authorized to provide the critical service, 4) Any other informal back-up caregivers the member has voluntarily selected. Members can also voluntarily select to have services wait until the next scheduled visit or specify an alternative plan of their choice on the form.

The CM reviews the remainder of the form with the member/representative and obtains a signature on the second page of the Contingency Plan form. The CM leaves a copy of the completed form with the member and maintains the original form in the member’s LTC case management record. The CM adds the member’s MSPL to the electronic case management database, which automatically transfers the MSPL to the Service Authorization Letter that is sent to the provider, so the provider is aware at the point of authorization of the MSPL selected and required.

The Contingency Plan process described above is also completed on current members who select to have a critical service any time after the intake process. At reassessment, the CM reviews the current Contingency Plan with the member and if there are no changes, the member signs the next signature line on the form. The form allows three reassessment reviews to be completed this way. A new Contingency Plan is completed at least once a year, but is completed more often when the member identifies any changes to the Contingency Plan form. Fresh copies of the Critical Service Gap Report form are also reviewed and provided once a year.

### **Member NPS Resolution**

Members are reminded to follow the Contingency Plan developed should a NPS occur. If the member calls the critical-service provider and is not able to get resolution of the NPS, or if the member’s informal back-ups are not available, the member is advised to call the CM immediately. The CM will work with the authorized provider to resolve the NPS so the member has the care they need based on the member’s MSPL. If necessary, the CM will coordinate care with a new critical-service provider to meet the member’s immediate needs.

If the member calls the AHCCCS NPS number and AHCCCS calls the plan, MCP Member Services will forward the call to the assigned CM during business hours. If the member calls after hours, after hours PA is instructed to authorize the service necessary to meet the member's needs until the following business day.

### **Informing Providers**

The NPS/Gap analyst in the LTC department provides training on the MSPL requirements and the NPS reporting requirements to the providers of the critical services. The analyst meets with any new critical-service providers face-to-face to provide training which includes a review and provision of 1) copies of the gap in service policy materials in the ACOM and AMPM, 2) the NPS spreadsheet, 3) the MercyOneSource provider portal specially designed for providers to enter in their NPS data, 4) the requirement to have a 24/7 phone line available for member's to call in. MCP requires that critical-service providers input their NPS data no later than the 5<sup>th</sup> business day of the following month in which the gap occurred.

The Analyst calls providers to clarify any information reported and provides additional training as needed. The Analyst also sends out a reminder letter to all the critical-service providers at the start of the summer and before Thanksgiving, times when holidays and vacations frequently take place. The letter reminds the critical-service providers of their responsibility to establish back-up caregivers and have them readily available on all holidays and when caregivers take vacation time or no-show regardless of the reason.

On an annual basis MCPs Provider Services Department also conducts after-hour and week-end calls to all critical-service providers to ensure they all have a working 24/7 phone line with a quick response time. Providers without a working number or poor response time must submit a corrective action plan to resolve the deficiency.

### **Tracking and Trending NPS/Gaps Monthly**

The analyst sends the NPS report and the Gap reports to AHCCCS by the 10<sup>th</sup> business day of each month for NPS/Gaps that occurred the previous month. To do this the analyst completes the following steps. First, the analyst pulls, reviews, and compiles the NPS data from the provider portal on a daily basis. The review includes identifying which NPS were actually Gaps and flagging those for the final review process.

Next, between the 6<sup>th</sup> and 9<sup>th</sup> business days the analyst reviews the NPS report in its entirety to identify true service gaps and trends. Per AHCCCS requirements the Analyst creates a separate Gap report spreadsheet and includes all the Gaps identified on the original NPS report.

If trends are identified on either report, the Analyst informs the provider, the CM, or both based on the nature of the issue. For example if the issue involves data entry, only the provider will be contacted; however if the issue involves response time to the member then both individuals are informed. When CMs are involved they are asked to contact the member to ensure their needs are currently being met and provide reeducation with regard to their rights in receiving services as authorized.

In the event that the analyst identifies significant issues or trends with critical service providers not meeting AHCCCS requirements, the Analyst works with MCP provider services department to send a formal notice to the provider and a CAP if needed.

In addition to information received from the providers, information received from Critical Service Gap Report forms or grievances filed are cross checked against the provider's submissions and added to the NPS report.

The analyst submits the reports to LTC Management for review and approval. The reports are then forwarded to the MCP Compliance Department for final submission to AHCCCS on or before the 10<sup>th</sup> business day of the month. If any questions arise from AHCCCS they work directly with the Analyst to answer questions related to the reports.

### **Semi-Annual Gap Reports**

MCP LTC Analyst is responsible for completing and submitting the semi-annual NPS/Gap report to AHCCCS. The November 15<sup>th</sup> semi-annual report includes data originally submitted from April to October, and the May 15<sup>th</sup> report includes data originally submitted from November to March. The semi-annual report includes a summary of figures and percentages using templates provided by AHCCCS. In addition to the figures and percentages the analyst includes 1) trends per month, 2) corrective actions taken, 3) grievances and appeals submitted, 4) results of annual phone testing, and 5) on-going education provided. The Analyst submits the semi-annual reports to LTC Management for review and approval. The reports are then forwarded to the MCP Compliance Department for final submission to AHCCCS on or before the 15<sup>th</sup> business day of the month the reports are due. They are reviewed and submitted to AHCCCS in accordance with the required timeframes.

### **Family Caregivers**

MCP recognizes that family members are a significant component in the success of the members in home placement. MCP case management staff takes action to support the family caregivers. MCP supports a very high percentage of family caregivers to best serve our members needs. Currently 59 percent of the MCP members receiving caregiver services are receiving them from are Family Caregivers.

### **Network**

MCP staff work collaboratively to develop and maintain a HCBS contracted network to meet the specialized needs of the members to allow members to reside in the least restrictive setting. This is a routine part of our ongoing contracting efforts.

**SECTION 18 – ALTERNATIVE RESIDENTIAL SETTINGS ACTION PLAN FOR CONTRACTOR WITH  
20% OF THEIR MEMBERS RESIDING IN AN ALTERNATIVE RESIDENTIAL SETTING.**

---

Approximately 15 percent of MCP’s members reside in an alternative residential setting. Therefore MCP is not required to submit an action plan at this time.

In conjunction with ACOM Policy *Provider Network Development and Management Plan*, IV. Procedure, if the number of members residing in alternative residential settings rises significantly to greater than 20% MCP shall take specific pro-active strategies/actions to reduce the percentage of HCBS members in Alternative Residential Settings should 20% or more of our HCBS membership resides in alternative residential settings. If this occurs, MCP will take specific action to reduce the alternative residential setting placement percentage and will demonstrate the implementation of our strategies/actions to decrease this percentage. These strategies/actions shall not lead to or incentivize an increase in the percentage of members residing in skilled nursing facilities. In the unlikely event that our rate increases to 25% a specific plan to decrease the rate shall be developed and reported to AHCCCS 15 days after the end of the quarter, until the rate is less than the 25% for two consecutive months.

**SECTION 19 – LISTING OF ASSISTED LIVING FACILITIES FOR WHICH MCP HAS ALREADY OBTAINED A WAIVER FROM THE SINGLE CHOICE OCCUPANCY REQUIREMENT**

*List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:*

	Assisted Living Center	AHCCCS ID #	City/Area Served	Exception Period
1.	Maryland Gardens	160139	GSA 52	10/10 – 9/11
2.				
3.				
4.				
5.				

SECTION 20 – LISTING OF NURSING FACILITIES THAT HAVE WITHDRAWN FROM THE  
MEDICAID PROGRAM

---

MCP does not utilize any skilled nursing facilities that have withdrawn from the Medicaid Program.

## SECTION 21 – DESCRIPTION OF HOW MERCY CARE PLAN WILL HANDLE THE LOSS (CLOSURE, CONTRACT TERMINATION) OF A MAJOR HEALTH CARE PROVIDER (HOSPITAL, NURSING FACILITY, LARGE PROVIDER GROUP)

---

Mercy Care Plan (MCP) has a well-established process for identifying potential losses of skilled nursing facilities (SNFs) and assisted living facilities (ALFs) and implementing protocols that provide for continued service to members. Under the direction of MCP's Chief Operating Officer, the Director of Network Development and Contracting is responsible for maintaining a viable provider network in the event of a contract termination or closure.

MCP complies with all AHCCCS and federal regulations regarding facility closures. We follow ACOM (section 421 – Contract Termination: Nursing Facility and Alternative Residential Setting) procedures which allow us to continue paying a facility for a member's care if they remain open and are contracted with another Program Contractor. If a facility is closing or if a nursing facility that is withdrawing from participation in the Medicaid program, MCP follows the applicable section of AHCCCS policy or federal regulations (42 CFR). When a quality of care event(s) occurs, we follow AHCCCS policy including notification to AHCCCS and external entities required by Chapter 900 of the AMPM.

### **Monitoring Network for Potential Loss**

MCP routinely monitors the network for viability and continuity, with focus on SNFs and ALFs with known or suspected viability problems or known to be at risk for closure. This monitoring serves as an early warning system and allows us to identify possible loss of a SNF/ALF, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members. The following are examples of key indicators used in our monitoring process:

- State licensure issues
- Medicare/Medicaid sanction reports
- Credentialing or re-credentialing concerns
- Failure to secure or renew required insurance
- Multiple facility requests within short time lines for advance payments to cover expenses
- Concerns raised by CMs, QM and PSRs that suggest that facility closure may occur
- Member or provider complaints about the availability of care or services

In addition to monitoring SNFs and ALFs, we maintain communication with officials from state agencies (e.g. Arizona Department of Health Services (ADHS)) to identify potential closures.

### **Addressing Loss of SNFs/ALFs**

MCP's primary concerns during SNF/ALF losses are the safety of members and continuity of care. We take the actions listed below upon learning of potential contract termination, closure for any reason, or serious quality of care concerns:

- Facilitate a meeting with the SNF/ALF and AHCCCS to be held prior to the effective date of contract termination or any change related to contract status that could have an impact on members and/or their representatives.
- Develop a communication plan that informs members and their representatives of the contract termination and the member's option to continue residing in facility until open enrollment. In a GSA with only one Program Contractor, we would work with the member regarding available options, which may include transferring to another facility. MCP submits the communication plan for approval by AHCCCS, provides impacted members with an explanation regarding the contract termination and informs impacted members of the steps they need to take during open enrollment.
- If MCP or an outside entity such as ADHS identifies quality of care events that place the member in immediate jeopardy, MCP offers the member an alternative placement. MCP's Medical Director may also engage the member's PCP to assist in explaining the seriousness of the situation. The member or member's representative retains the right to stay at the current facility or choose an alternative placement.
- Maintain a policy to disallow new admissions to a SNF/ALF when there are quality of care or contract termination issues. Our Medical Director also evaluates readmission to a SNF/ALF after admission to an acute setting to verify that the readmission is appropriate.

### **Member Transition During a SNF or ALF Loss**

- MCP follows established procedures when it becomes necessary to relocate a member who resides in either a SNF or ALF from one contracted facility to another due to a closure. In these circumstances, MCP coordinates a seamless transfer of the member to a SNF/ALF within the same geographic or nearby location in a safe and organized manner. The process involves coordination and communication with internal departments, ADHS, AHCCCS, the transferring and receiving facilities, members and their families, and affected providers, as described below:
- After communication with ADHS and AHCCCS, MCP's Vice President of Long Term Care (LTC) chairs an internal meeting with management and staff from multiple MCP departments to apprise them of the situation and communicate next steps.
  - The LTC Manager establishes a team consisting of the LTC Management Supervisor, the member's assigned LTC Manager, and the medical provider assigned to the facility. The LTC Manager develops a master list of all members located in the facility and their associated medical provider. The LTC Manager calls each member and/or family member to discuss the facility closure and available options which may include relocating to a new SNF, moving to an ALF setting, or returning to the community with home and community based services. The team takes the following actions:
    - Determines the order in which members will be relocated, including identifying members who may need special consideration for placement (i.e. high risk members with unstable medical conditions or significant behavioral health issues)
    - Contacts SNFs/ALFs to identify bed availability and determine how many transfers each facility can accommodate. LTC Managers consult with the Foundation for Senior Living Community Living Services staff to help identify adult foster care and ALFs that best meet the needs of specific members
    - Verifies (in coordination with ADHS) that there is monitoring of the releasing facility for staffing, food, and supplies as necessary until all of the members are moved
    - Coordinates placement including contacting family or representatives and completing authorizations

- Provides the releasing facility with the names and contact information of MCP staff to be contacted for more information related to the member's transfer
  - Works with medical and other contracted providers to notify them of transfer and arrange for supplies, DME, pharmacy and additional PCP coverage as needed for the member's transfer orders
  - Arranges transportation to the member's new location and for transfer of copies of medical records, medications, supplies/DME, personal belongings and trust fund accounts to the receiving facility
  - Visits the facility daily, including weekends and holidays, until all members have been relocated. The LTC Manager also visits each member daily to identify and address any issues
  - Creates a final list of all members who have been moved and destinations
  - Within one week of transfer, provides a case management visit to each member and contacts the member's family to identify and assist with any issues resulting from the transfer
  - The member's LTC Manager assists the member with the change of SNF/ALF. Under each circumstance, we provide translation services for members during transition to avoid misunderstanding, reduce anxiety, and facilitate quality of care
- Upon completion of the transition process, MCP's Vice President of LTC conducts a follow up meeting with internal departments to verify that the transfer process has been appropriately implemented and address any questions or concerns.

### **Case Study**

- MCP was notified of an Assisted Living Center (ALC) for which DHS had completed a survey and determined that an immediate jeopardy existed due to lack of appropriate staffing, sanitation and quality of care issues. MCP had approximately 40 residents there. After communication with ADHS and AHCCCS, MCP's Vice President of LTC initiated an internal meeting which included Compliance, Quality Management, Provider Services and Member Services to develop an action plan and immediately took the following steps:
- Vice President of LTC notified other internal departments (i.e. Current Review, Prior Authorization) to discontinue referring any new members to the facility
  - LTC Management Supervisor determined the number of members in the ALC and other Program Contractors involved
  - Vice President of LTC developed and submitted a communication plan to AHCCCS for approval, which informed the member or their representative of the pending contract termination and actions proposed and explained member's rights in these situations
  - LTC Management Supervisor created a list of members (including levels of care) and family members to contact, as well as assigned LTC Managers and developed a plan to assist in assessment and relocation
  - LTC Management Supervisor met with the LTC management team to review assignment of members to contact at the facility
  - LTC Managers met with each member and/or the member's representative to discuss their options for placement and verify that they agree
  - LTC Managers developed a census of all other ALC beds available in the area

- LTC Managers created a list of high risk members and determined immediate plans to relocate members (including options available options to the member)
- Vice President of LTC informed AHCCCS of our intent to initiate contact of members and decision makers about the development and provide for the member's health and safety by offering relocation
- LTC Management Supervisor notified the facility our intent to relocate our members
- LTC Managers monitored the facility with daily visits
- LTC Management Supervisor and LTC Manager attended meetings coordinated by DHS to discuss their findings
- LTC Managers informed members who chose not to relocate of their rights to remain at the facility and actions they would need to take during the next open enrolment period
- LTC Managers coordinated transportation and transfer of medical records, medications, supplies/DME, personal belongings and trust fund accounts to the receiving facility
- LTC Manager determined which members required translation services to provide for a safe transfer and arranged as necessary
- LTC Management Supervisor maintained a list of members relocated to the new facility and any identified obstacles related to the move
- After completion of transition and transfers, the Vice President of LTC arranged a meeting with all internal departments that were involved to discuss the outcomes

SECTION 22 – DESCRIPTION OF THE METHODS USED TO ENSURE THAT ALTCS MEMBERS  
RECEIVE NEEDED SERVICES IN THE EVENT OF A NATURAL DISASTER

---

**Natural Disasters**

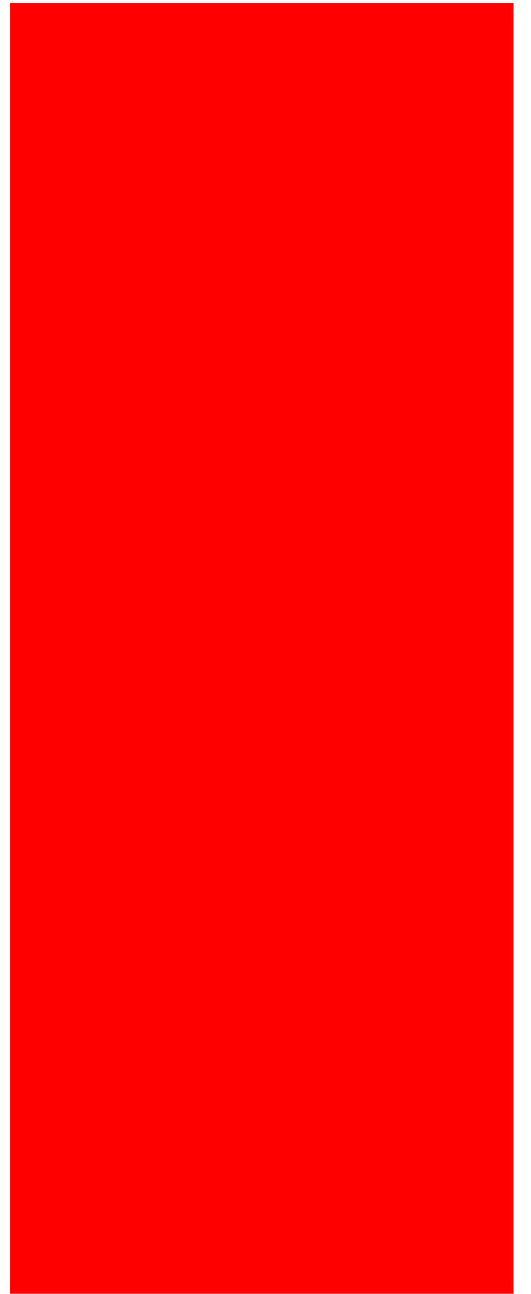
MCP has an established Disaster Recovery Plan (DRP) and Business Continuity Plan (BCP) that are maintained, tested, and managed by our compliance and operations departments. Together, these plans (DRP and BCP) address various potential disasters that could impact continuity and delivery of care to our members, operations, or systems, and detail the recovery efforts that we would implement to minimize the impact on continuity and delivery of care to our members and maintain operations. The BCP contains a section that specifically addresses the loss of network providers. In the event of a major disaster, such as an epidemic that compromised the employees of an entire rural hospital, MCP would postpone elective procedures, put in place mechanisms to transport members to the nearest facility, notify providers and members of the closure, and arrange for increase case/care coordination for members that will need to be transitioned or transported. Our BCP requires the participation of MCP and corporate employees and executives in cooperation with local and state disaster officials. It is our standard operating procedure to notify AHCCCS and coordinate our procedures in the best interest of our members.

**SECTION 21 – APPROVALS**

The Network Development Plan is evaluated, updated and submitted to AHCCCS within 45 days from the start of each contract year.

Signature: 	March, 2011
Christi J. Lundeen, Vice President – Strategy and Business Development	
	March, 2011
Lorry Bottrill, Chief Operating Officer	
	March, 2011
Mark Fisher, Chief Executive Officer	
	March, 2011
Kevin Phelan, Director – Network Development & Contracting	
	March, 2011
Jennifer Sommers, Director - Provider Services	

37.



### **Question 37 – Provider Network**

Mercy Care Plan (MCP) is proud and pleased to propose expansion of our programs of high quality and responsive care and services to the Pima and Santa Cruz GSA. We currently provide the full range of AHCCCS covered services to almost 30,000 members in Pima County. Through our Medicare Advantage Special Needs Plan we also serve 15,669 state-wide dual eligible members, with 1,800 in the Pima and Santa Cruz GSA. Our history and experience in Pima and Santa Cruz, beginning in 1984, gives MCP market insight while we actively build a comprehensive network. For instance, one of our owner hospitals – St. Mary’s Hospital – has been serving the poor and disadvantaged in Tucson since 1880 and Holy Cross Hospital has been serving Nogales since 1987. This gives MCP a unique understanding of the provider community and this GSA.

MCP’s collaboration with Community Partnership of Southern Arizona (CPSA) also affords us a unique understanding of the provider community in this GSA. As the Regional Behavioral Health Authority in the Pima Region for the past 16 years, CPSA has a comprehensive service network and relationships with a vast array of providers. Through our agreement with CPSA, we will expand our behavioral health expertise and broaden services to enhance our excellent behavioral health network for ALTCS members. CPSA’s long standing relationships in the Pima and Santa Cruz GSA will provide a valuable source of information and experience for expanding and managing our comprehensive provider network.

MCP’s Director of Network Development and Contracting manages the process of building the network working in collaboration with CPSA, Carondelet, and MCP departments (e.g., Medical Management, ALTCS Case Management, Behavioral Health, Finance, and Provider Services). The purpose of this collaboration is to create a provider network development strategy that supports the goals of providing accessibility to care; reducing avoidable emergency department visits, inpatient admissions, and re-admissions; allowing members to remain in their residential locations; collaborating with stakeholders; and improving outcomes while saving costs. The core of our network development strategy in the Pima and Santa Cruz GSA is to immediately respond to and proactively avoid network gaps, develop provider education protocols for a mix of new and continuing providers, and work with community-based stakeholders to achieve a smooth transition for ALTCS members to MCP.

The key to our success in the Pima and Santa Cruz GSA is provider training. Our training program includes local Provider Services Representatives (PSRs) dedicated specifically to ALTCS providers. This is an extension of our provider services program that we have perfected in the Maricopa GSA. Our ALTCS PSRs become experts in ALTCS program standards, contractual requirements, policies, case management protocols, and issues common to HCBS, assisted living facilities and nursing home providers. For example, MCP does not participate in roster billing and our PSRs will offer an education and assistance program for providers on standard billing, electronic claims transmission, and Electronic Funds Transfer (EFT) enrollment.

### **Pima and Santa Cruz GSA Long Term Care Network**

MCP recognizes the importance of member continuity for long term care specialized services and placements. As such, we have created a network that will support the member’s ability to maintain their existing care and support providers. Our experience with the ALTCS program in the Maricopa GSA gives MCP the expertise necessary to recognize the enhancements needed to create a network that offers greater choice to the member. Our network includes:

- For HCBS services such as the attendant care program, we have contracts with all major providers including “PCOA for All”, Dependable Health Services and Soreo
- MCP has written agreements with over 90% of all Alternative Residential Facilities. In the event that a member resides in a facility where no agreement currently exists, MCP will enter into a one-time letter of agreement until such time that a contract can be put into place.
- MCP has agreements with all skilled nursing facilities in this GSA. Our collaboration with CPSA increases the capacity for behavioral health support to members residing in nursing facilities. Our experience shows that having behavioral health providers available to intervene promptly with members and facility personnel can often preserve the placement at the least restrictive level of care and reduces the need for high cost, high intensity specialty settings. CPSA’s Consultation and Clinical Intervention (CCI) Program, for members at risk of placement disruptions, provides prevention of and successful intervention in crisis to avoid loss of placements, ED visits and lengthy, unnecessary Level I admissions. CCI includes a multi-disciplinary team that provides comprehensive consultative crisis assessments, functional analyses, and the development of behavioral plans to prevent crisis that may lead to placement disruptions.

## **Provider Recruitment and Collaborative Arrangements**

MCP provides the highest quality and responsive care to AHCCCS members in the Pima and Santa Cruz GSA and already has current contracts and excellent working relationships with many key ALTCS providers in this GSA. We have executed written agreements with providers that meet all ALTCS program requirements. Our network development approach is as follows:

- Compare overlap between our existing and expanded Pima and Santa Cruz network with the incumbent's network. Execute contracts with providers in the incumbent's network if they are non-participating with MCP.
- Replicate innovative network arrangements from our ALTCS Maricopa GSA (see below) to address specialized needs of ALTCS members and to meet ALTCS program goals
- MCP will utilize our knowledge and experience relative to the transition of members and will cooperate with AHCCCS to appropriately transition all members with a commitment to continue current services for ALTCS members for the first 90 days

One of the hallmarks of our ALTCS network is our innovative contracting arrangements with providers and community organizations. We will expand our successful models implemented in the Maricopa GSA to the Pima and Santa Cruz GSA. Examples of programs we will implement in Pima and Santa Cruz GSA include:

- Arrangements with Tucson House Calls and Triad Medical Group to provide PCP visits in members' homes or residential settings during the day, evenings and weekends.
- An arrangement with urgent care facilities that offer improved access to after hours care.
- To evidence our strong commitment to patient center medical homes (PCMHs), MCP has identified several practices in Pima County for implementation as PCMHs during CY 2011.
- In collaboration with the Carondelet Medical Group and the University of Arizona in Pima County, we will launch a diabetes management program in CY 2011 that focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and telehealth for at risk members.
- Expansion of our behavioral health network and programs in Pima and Santa Cruz Counties through collaboration with CPSA. As a result of this agreement we are further expanding our behavioral health expertise and broadening services to enhance our excellent behavioral health network for ALTCS members. CPSA's CCI Team is an innovative approach for assessing members at high risk for placement disruption and designs services to meet members' needs. As the RBHA in the Pima Region for the past 16 years, CPSA has a comprehensive service network and relationships with a vast array of providers. CPSA will facilitate access to a full continuum of behavioral health services available to members in Pima County upon contract award.
- Improving services to homeless members through the Southern Arizona Health Village for the Homeless Van of Hope community collaboration. This program provides mobile medical services at sites frequented by homeless members.
- We have long-standing and effective agreements with FQHCs in the Pima and Santa Cruz GSA, including El Rio Health Center, El Pueblo Clinic, Marana Health Center, Mariposa Community Health Center, Desert Senita Community Health Center, and United Community Health Center.
- Our network also includes covered services available through advocacy groups such as the Pima Council on Aging in Pima County and Southeastern Arizona Behavioral Health Services, Inc. for behavioral health and substance abuse services in Nogales.

Our priority in planning and developing the Pima and Santa Cruz GSA expansion is to promote comprehensive member-centered care. We have a provider network in place that is capable of providing covered and medically necessary services with availability consistent with and often exceeding AHCCCS standards. We offer a comprehensive network that will support and allow members to reside in the least restrictive setting with access to integrated care. To this end, our network has the flexibility, capacity, and depth to meet the needs of ALTCS members in the Pima and Santa Cruz GSA. We have extensive experience transitioning elderly and disabled members and this experience will be valuable in facilitating transfer of members. Our provider network, including home and community based providers, alternative residential settings and case management programs will give the Pima and Santa Cruz GSA membership access to care that is either equal or superior to the existing program. We offer a local team to address any identified gaps in services for an individual member. While we expect gaps to be minimal, our Network Development, Medical Management, Case Management, and



Member Services team will be available to work cooperatively with the member, the member's family/caregiver<sup>13</sup>, and PCP to resolve any problems.

Based on our knowledge and experience we have constructed a network that will also meet the cultural and linguistic needs of the ALTCS membership in the Pima and Santa Cruz GSA. Our network maximizes community-based primary care and specialty care services. We are proud to include the Marana Health Center, El Rio (all clinic locations and services – including the Broadway Clinic for the homeless and behavioral health services), Mariposa (Nogales, Rio Rico and Patagonia locations), Desert Senita Community Health Center (Ajo) and United Community Health Centers (Green Valley, Sahuarita, Three Points, Arivaca and Amado locations) in our network. These organizations offer high quality and accessible community-based health care services.

MCP is actively pursuing agreements with providers who contract with the incumbent in the Pima and Santa Cruz GSA, and anticipate that we will have signed agreements prior to the readiness review. However, in the unlikely event that some providers remain outside our participating network by this date, MCP has a process to transition care and avoid continuity of care issues. We will accomplish this by arranging single case letters of agreement with existing providers while we finalize agreements with the provider(s). We will never disrupt a member's on-going course of treatment with an out of network provider until either the treatment has been completed or the member's condition is stable enough to allow a transfer of care. We will offer a process to prepare the member and the member's caregiver - in conjunction with the PCP and assigned Case Manager (CM) - for the transition. MCP will assign a CM to each member who will act as the member's advocate, verify that we preserve continuity of care, and implement a seamless transition. Should MCP identify a network gap, we will communicate the information to our network development and contracting staff who will take appropriate action.

In addition to the assigned case management support, MCP has a 24/7 member services department available to members, member's families/caregivers and providers as a further resource to resolve any transition challenges. Member services personnel will receive training to facilitate handling of any call or issue. Personnel from our Medical Management, Pharmacy Management, Network Development, and Provider Services Departments will be available to quickly resolve any member, member's family/caregiver or provider concern. Our planned Pima GSA Transition Helpline will be operational August 2011 until January 2012.

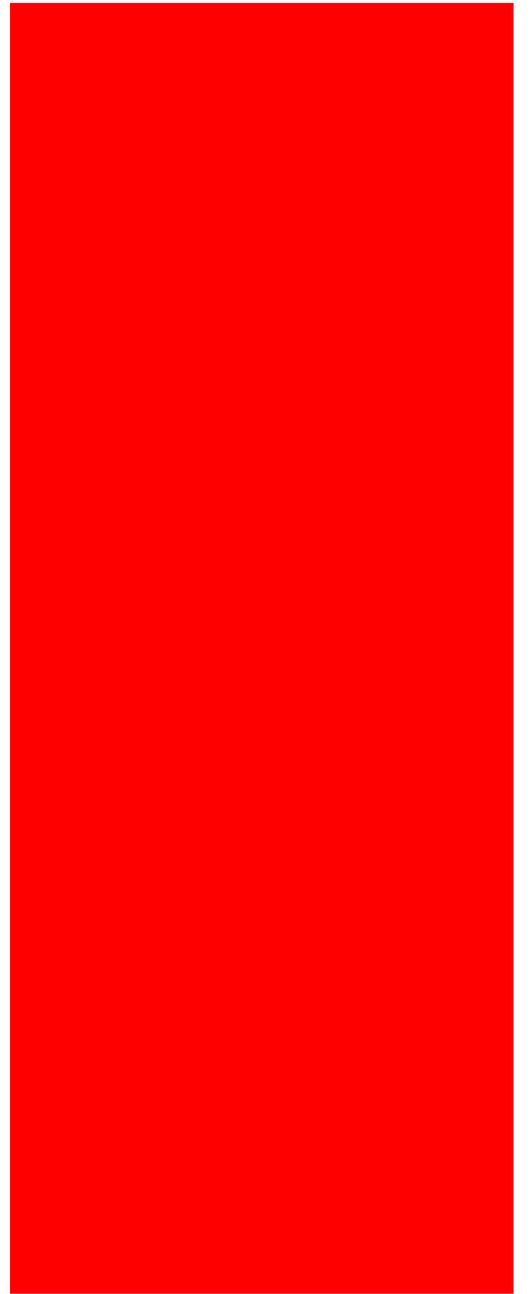
MCP has developed a Southern Arizona Community Support and Services Team (SACSST) which will be engaged in the Pima and Santa Cruz GSA readiness review and implementation. SACSST will be our community-based advisory and steering committee for network finalization and implementation efforts in the Pima and Santa Cruz GSA. Our COO will chair SACSST and we anticipate that committee members will include members, members' families and/or caregivers, community-based stakeholders, adult protective services, key providers, AHCCCS, and our CMO and vice president of strategy and business development. The roles of SACSST will be to: 1) identify providers who should be part of our network; 2) provide guidance during the readiness review and implementation effort; 3) support outreach to critical non-participating providers and organization; 4) advise on implementation and transition planning; 5) facilitate and fine tune our program to support providers during roster billing conversion; and 6) other responsibilities necessary to execute a smooth care transition process.

In the event we receive a contract to serve ALTCS members in the Pima and Santa Cruz GSA, MCP is proposing a PERFORMANCE GUARANTEE as a contractual commitment of our satisfactory completion of certain activities related to our Pima and Santa Cruz GSA proposal. This PERFORMANCE GUARANTEE will be in the form of a two part performance bond. Part one is MCP's successful and timely entry into the Pima GSA. Part two will be that MCP fulfills certain service standards, such standards to be agreed to by both AHCCCS and MCP and related to MCP's first year of operation in the Pima and Santa Cruz GSA. MCP will post both performance bonds, each in the amount of one million dollars (\$1,000,000) at the beginning of the readiness review phase. The terms and conditions of these performance bonds will be discussed during contract negotiations and based on our mutual agreement of a contract amendment between AHCCCS and ALTCS that will be executed. These performance bonds are not to be confused with the performance bond requirements as stated in RFP YH12-0001 Section D, paragraph 46 or ACOM Chapter 300, section 306.

---

<sup>13</sup> Herein after, all references to "family/caregiver" include the member's guardian

38.



### **Question 38 – Provider Network**

Mercy Care Plan's (MCP's) standard operating procedure is to design, implement, and manage a provider communication process that provides timely, accurate, and complete provider information regarding changes to program standards, laws, regulations and AHCCCS subcontract requirements. Our provider communications program recognizes and acknowledges that health care communication has become increasingly complex and demanding – our providers have to filter complex data, information, and messages from multiple sources every day. Our goal is to effectively and efficiently communicate with our providers to minimize any unnecessary disruption to care to our members. Our provider communication process will also facilitate and support our providers during this period of unprecedented budget shortfall. Our communication processes, methods and approaches are effective and efficient in having even the most difficult and complex message delivered to and understood by our providers.

Communication with our provider network begins before providers join our network and continues thereafter. Our MCP provider communication program is designed to inform our providers about: 1) program standards, and Evidence-Based Clinical Practice Guidelines, 2) changes in laws and regulations, and 3) changes in AHCCCS minimum subcontract or other subcontract provisions. We tailor our provider communication program upon receiving input from providers. For example, provider input led MCP to streamline provider communication so we can more clearly have our message(s) reach providers. Under the direction of our Chief Operating Officer (COO), input from physicians on our QM/UM Committee and advice from local community-based providers, we have improved our provider communication program.

### **Provider Communication Methodology**

Reporting to the COO, the MCP provider services director (PSD) has overall responsibility for coordinating communications between AHCCCS and our network providers. Under the direction of PSD, our dedicated ALTCS specific Provider Services Representatives (PSRs) serve as the provider's primary-point-of-contact for inquiries, complaints and requests for information relative to the ALTCS program. ALTCS PSRs continually disseminate information regarding program standards and changes and communicate with the provider network through various means of communication, including new provider orientation, proactive regularly scheduled meetings with network providers, association meetings (e.g., Arizona Assisted Living Home Association (AALHA) and Arizona Health Care Association (AHCA)) website postings, and written communications.

MCP uses a multifaceted provider communication approach that relies on a variety of communication methods each with the same goal: to confirm that our providers are aware of AHCCCS' regulations and MCP program enhancements and modifications. An effective and efficient communication system is necessary to share best practices, recognize the PCP's role in medical decision-making and promote strong physician leadership, promote member health through provider incentives and support each member living in the least restrictive setting.

Because of the complexities of the ALTCS program, MCP has designated PSRs who are specially trained and dedicated to the specialty provider types associated with this program. Our ALTCS PSRs receive specific training regarding the ALTCS program and covered services as well as standards, regulations, policies, case management, and the special needs of ALTCS members including their cultural and linguistic needs. ALTCS PSRs specialize in nursing facility, alternative residential settings and home and community based service providers. When a provider contacts their designated PSR they know their inquiry, complaint or request for information will be responded to in an accurate, complete and prompt manner. . This dedicated team is a key factor of our provider communication success. MCP is enhancing our relationships to include new long term care specialties within our provider network in the Pima and Santa Cruz GSA and will continue to apply these same approaches and collaborative efforts with our providers in this new GSA.

### **Provider Orientation**

MCP performs extensive, on-site, provider orientations for every newly contracted provider, including HCBS providers and nursing facilities. Our ALTCS PSRs facilitate an in-depth review of AHCCCS program standards, state and federal guidelines, laws and regulations, AHCCCS minimum subcontract provisions, the provider contract, the provider manual, utilization review programs (prior authorization, concurrent and retrospective review) formulary/preferred drug list, website and other pertinent materials. Providers receive information on MCP's process for communicating changes regarding: 1) our contract with AHCCCS, 2) program standards, 3) laws and regulations, or 4) AHCCCS or other minimum subcontract provisions. We also educate providers on their roles and responsibilities as a network provider for the ALTCS program including, but not limited to, the following:

- Understanding the guiding values for serving members with long term care needs

- Coordinating and providing member-centered care to our members including initiating referrals for necessary specialty care
- Verifying our members receive the most appropriate level of care in the least restrictive setting consistent with personal health, safety, and cultural beliefs
- Maintaining the member's medical record including documentation of all services provided and any referrals for specialty services
- The role of the member's Case Manager (CM)
- Specific orientation to all providers of attendant care, personal care, homemaker or respite services, including:
  - Completion of MCP's on-line non provision of service (NPS) log
  - Requirement for 24-hour, 7 day per week phone availability
  - Requirement to fill a gap in service within 2 hours of a member request
  - Direct care workforce training requirements

### **Provider Site Visits and Provider Meetings**

- After joining the network, MCP supports and monitors our providers through regular site visits or provider meetings. PSRs communicate program standards and changes in laws, regulations, and minimum subcontract requirements during the following; site visits include regularly scheduled meetings and adhoc visits to physician practices to facilitate ongoing training and review of recent network communications we have issued. MCP conducts site visits at a minimum of 1) four times per year for PCPs, 2) two times per year for obstetricians, 3) two times per year for dentists, and 4) one time per year for specialists.
- MCP collaborates with AHCA to provide quarterly skilled nursing home educational forums. These meetings are designed in a two-hour format with the first hour dedicated to administrators and directors of nursing where CEUs are offered. The second half of the meeting is dedicated to MCP policies, updates and changes in program requirements. The opportunity to receive CEUs has increased overall participation and provider satisfaction with MCP.
- MCP is developing and will implement quarterly meetings with home and community based providers in preparation for CY 2011
- MCP communicates with hospitals and ancillary providers on a regular basis as well by facilitating Joint Operating Committee meetings on a monthly or mutually agreed upon basis.
- MCP offers a cultural competency workshop for all network providers

### ***Provider Contract and Amendments***

Our provider contracts contain all of the AHCCCS requirements regarding program standards, laws, regulations, and subcontract requirements. We often use amendments as part of our communication process to formalize changes in program standards, laws, regulations, or subcontract requirements. These changes are communicated to providers through site visits, provider website bulletins, mailings, and general website updates. Amendment requirements and procedures are included in the provider's contract and we review this process with providers. One of the improvements in our provider communication process, based on provider input, is that most amendments do not require provider signature and are deemed accepted unless the provider submits written objection within 30 calendar days. It is our policy to send mailings containing contract updates or changes by certified mail, return receipt requested, thus allowing the mailing to be documented. For nonmaterial changes in our policies or programs, we include a notification in the provider's claims remittance advice. Our PSRs discuss amendment contents at regularly scheduled site visits to verify that providers received and understood the amendment.

MCP requests approval from AHCCCS of material changes (as defined by AHCCCS) to our business operations or provider network 60 calendar days in advance of the expected implementation. We cooperate with AHCCCS during the review process and understand that AHCCCS may comment or intervene if the change to our policy/process will cause an adverse affect to the overall system.

Upon AHCCCS approval, MCP informs providers of a material change at least 30 calendar days in advance. Our policy is to: 1) send providers written notification that describes the change, timeline for implementation and impact on the provider (using certified mail when appropriate), 2) post the information on our website, 3) if necessary, issue a special provider website bulletin or mail a letter for major changes, 4) discuss the information during office visits or meetings, and 5) coordinate closely with AHCCCS to minimize the affect on members or providers.

### ***Other Written Communication***

In addition to the provider contract and amendments, we use written materials to assist providers in understanding their contract requirements as well as changes to contract requirements, program standards, and state and federal laws and regulations.

Provider Manuals are updated as often as necessary and are available via our website for ease of access. For ease of reference, MCP created three provider manuals – one for each line of business (Acute, ALTCS and MCA). Each manual contains specific details of the program requirements for referrals, benefits and coverage limitations. Providers may print a hard copy or save an electronic version on a CD. The provider manual and its updates reflect current requirements and practices and serves as the provider’s principal resource document. PSRs review changes during site visits and verify that providers received and understood the updates.

Mailings are personalized letters disseminated to each affected provider at the same time to inform the network of program modifications. Mailings may also include notifications sent with the provider’s claims remittance advice.

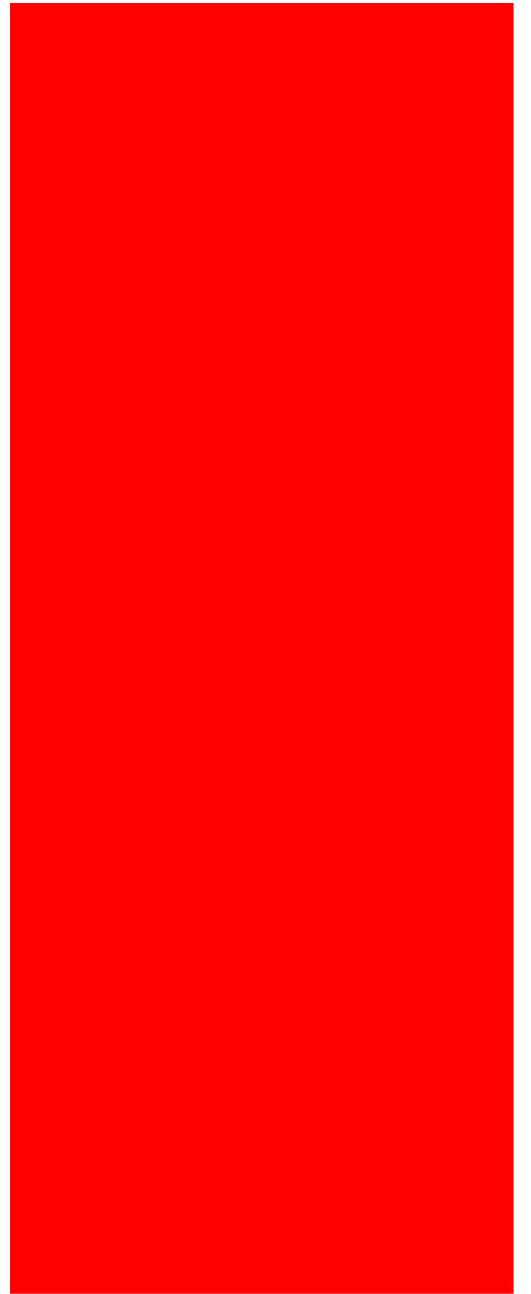
Updates to Website include current information and materials that are a reliable source for providers to receive timely, complete, and accurate information. MCP refers our providers to the website for access to information on program standards and changes to laws, regulations, and subcontractor requirements. Our website also includes other topics such as member eligibility information, prior authorization guidelines, formulary, Evidence-Based Clinical Practice Guidelines, the provider manual, and MCP preferred drug list.

MCP will use these methods, in addition to site visits and provider meetings, to communicate program changes that may affect providers, such as updates to fee schedules and benefits.

### **Collaborative Relationships**

MCP’s dedicated ALTCS PSRs enhance provider communication through collaborative working relationships with staff in other MCP departments as well as external entities. For example, our LTC CMs, Medical Directors, and quality staff conduct site visits and interface with providers on a daily basis as part of routine activities. These employees provide supplemental education and feedback regarding MCP initiatives or program changes.

39.



### Question 39 – Provider Network

Mercy Care Plan (MCP) understands the only thing more important than obtaining information regarding the performance of our provider network is utilizing those results to manage and improve network efficiency. Our Chief Operating Officer (COO) has overall responsibility for monitoring, managing, and improving the performance of our network providers. Under the direction of our COO, various MCP departments contribute to the process of monitoring and managing the network.

#### Obtaining Information

Although our Provider Services Department has primary responsibility for managing the network, MCP personnel from Long Term Care (LTC) Case Management, Medical Management, Quality Management (QM), Grievance and Appeals, Compliance, and Member Services work cooperatively to review results from monitoring tools and implement activities that improve the network. We gather information from several sources of data. The table below shows some of the main provider issues we have identified through these sources.

Issues	Sources of Data/Information
<b>Access/Availability</b>	GeoAccess reports, appointment availability and after-hours accessibility surveys, member and provider satisfaction surveys, member grievance and appeal reports, provider to member ratios, and PCP open panel reports
<b>Network Gaps</b>	GeoAccess reports, access and availability audits, member complaints, appeals and grievances, and feedback from other departments
<b>Quality of Care</b>	Medical record reviews, member grievances, adherence to Evidence-Based Clinical Practice Guidelines, credentialing reports, peer review reports
<b>Utilization of Services</b>	Case management, concurrent review and prior authorization reports and staff feedback; member grievances; claims reports (including pharmacy data), physician profiles
<b>Claims/Operations</b>	Provider claims disputes, claims and encounter data reports, provider satisfaction surveys, feedback from provider site visits

#### Communicating Issues

MCP uses data obtained from the above sources to share information internally, as interdepartmental communication is an essential part of MCP’s network monitoring and management activities. In doing so, we work cooperatively across departments to communicate issues and take actions to improve the network. We encourage departments to share provider issues across the organization by providing forums to collaboratively discuss issues and contribute to solutions. Communication avenues include workgroups, formal committee meetings, and informal daily interactions.

Workgroups include managers, directors and staff from multiple departments who review real-time data and resolve issues. They also review data trended over time to identify provider-specific or network-wide patterns to escalate to senior management and formal committees for further direction. MCP has dedicated workgroups that focus on topics such as member grievances; member appeals and claims disputes; operational topics such as contract configuration, provider data and claims research; and LTC network needs specific to ALTCs members. Key MCP committees that are involved with managing the network include the Quality Management/Utilization Management Committee (QM/UM Committee), Peer Review Committee, Credentialing Committee, Pharmacy and Therapeutics Committee, and the Strategy and Business Development Council.

#### Managing the Network

MCP workgroups and committees use data to analyze issues and implement improvements to the network, differentiating concerns that apply to a particular provider versus the aggregate network. Examples of how we use data sources and interdepartmental communication to manage the network are:

Verifying that services are provided in accordance with AHCCCS standards – MCP monitors provider accessibility and availability to verify that the network performs according to AHCCCS standards. Monitoring activities include review of data from GeoAccess surveys, appointment availability and after-hours accessibility surveys, member and provider satisfaction surveys, member grievance and appeals, provider to member ratios, and PCP open panel reports. The Provider Services Department reports data from these measures to the QM/UM Committee and Strategy and Business Development Council. In addition, MCP’s member grievances workgroup identifies and facilitates resolution of accessibility and availability issues as they arise and reports trends and activities to the QM/UM Committee.

Addressing network gaps - MCP uses data from GeoAccess, access and availability audits, member grievances, and feedback from other departments to identify current network gaps and potential future needs. For example, we review GeoAccess results annually as part of our Network Development and Management Plan and use the data to identify areas where we need to enhance the network across certain geographic service areas or specialties. We supplement this analysis with member satisfaction surveys and member grievances to verify areas for improvement, and feedback from our LTC workgroup which identifies network needs specific to long term care. Our QM/UM Committee reviews trended member grievances and satisfaction survey data and makes further recommendations. Our Strategy and Business Development Council uses feedback regarding network gaps to identify new network initiatives. Provider Services also works individually with LTC Case Management, Medical Management, or Quality Management who may identify potential network gaps during routine activities. When this occurs, employees work with our Provider Services Representatives (PSRs) to identify available contracted providers or to coordinate arrangements with a nonparticipating provider.

Addressing member grievances regarding providers – MCP developed a workgroup that meets weekly to address escalated member-initiated concerns regarding specific providers. Provider Services (for non-quality of care concerns) or Quality Management (for quality of care concerns) follow up with providers and report feedback at meetings. In addition to real-time follow up, MCP produces a monthly grievance report that identifies the type of grievance, including trends that indicate potential network need versus a performance issue of a specific provider. We report trends to our QM/UM Committee which may recommend additional provider or network specific interventions to address member concerns. MCP's Credentialing Committee and Peer Review Committee also review grievances as part of the re-credentialing and peer review processes.

Improving the quality of services delivered by providers – QM personnel review information from medical record reviews, member grievances, and provider site visits to improve the quality of care. The QM Department conducts provider outreach regarding preventive health services, including dissemination of Evidence-Based Clinical Practice Guidelines and letters that identify members in need of preventive health services. QM nurses also conduct medical record reviews to evaluate the accuracy and completeness of documentation regarding the member's health status and services provided, and provide recommendations to providers. In addition, QM personnel attend member grievance workgroup meetings; follow up with providers regarding quality of care concerns and report results to the workgroup. QM personnel work closely with MCP's medical director during these activities and present reports at the QM/UM Committee meeting. MCP's Credentialing Committee also reviews information specific to a provider's quality of care while conducting re-credentialing and the Peer Review Committee considers information if providers are recommended for peer review.

Addressing appropriate utilization of services – MCP's Medical Management Department, including Prior Authorization and Concurrent Review, evaluates requested and current services against established utilization management criteria to verify appropriate utilization of services. We follow up in real-time with providers through case management, concurrent review and prior authorization activities, and through our member grievance workgroup which identifies provider specific grievances related to utilization of services. We use claim reports (including pharmacy data) to monitor trends in previous services provided by individual physicians and the network overall, and to identify providers whose utilization practices continue to vary over time. MCP reports member grievances and trended utilization data to the QM/UM Committee. In addition, our Pharmacy and Therapeutics Committee reviews drug utilization data and makes recommendations regarding MCP's preferred drug list, and reports to the QM/UM Committee.

Facilitating operational changes that promote network effectiveness – Using feedback from provider satisfaction surveys, site visits, and provider claims disputes, MCP addresses provider concerns to minimize administrative hurdles. MCP has a workgroup focused on provider claims disputes and health plan operations, where MCP researches claims issues down to the root cause, which may be due to incorrect provider claim or encounter submission, a provider add/load issue, or system set up issue where the claim was not set to pay according to the provider's contract. MCP also gathers feedback during site visits and from provider satisfaction surveys regarding our operational processes and policies. MCP's Provider Services Department reviews feedback and follows up with providers. In addition, our QM/UM Committee reviews results from provider satisfaction surveys and recommends follow-up actions, and our Strategy and Business Development Council uses data to identify network initiatives.

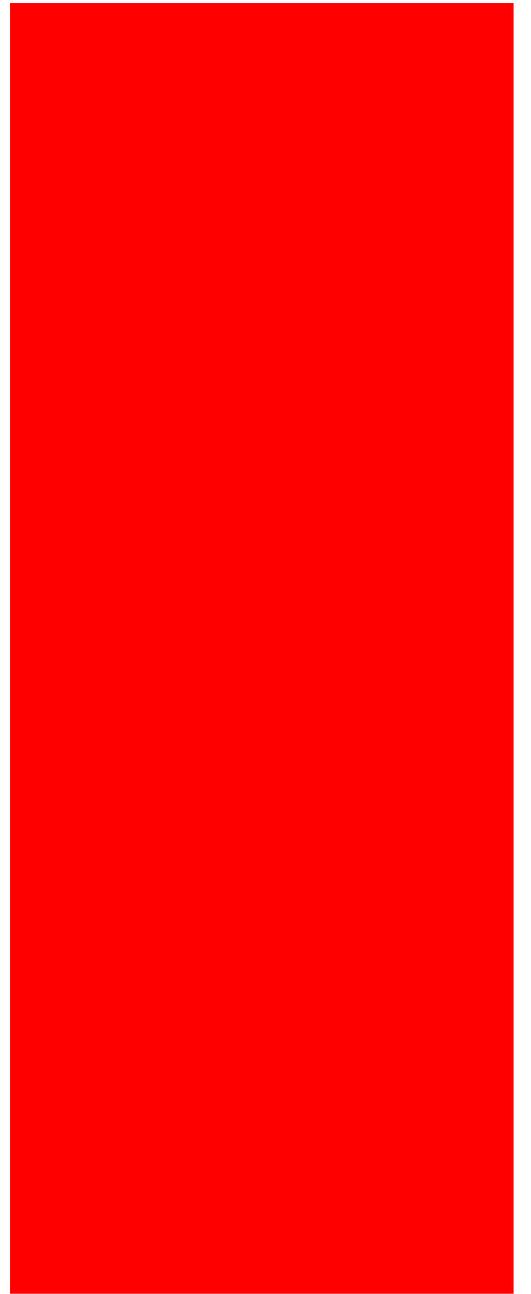
### **Example of Using Data and Communicating within MCP**

In 2010, MCP identified a number of issues in our capitated agreement with our laboratory service provider. The issues ranged from reporting encounter data, claims payment for capitated services and lack of service support offered to our assisted living and skilled nursing facilities by our existing contracted lab provider. Analysis of the claim data showed

that our lab provider was not submitting encounters according to the requirements in their provider agreement with MCP. Further, we identified areas where fee for service payments were issued for services that should have been covered under the capitation arrangement. MCP PSRs educated the lab provider regarding the issues and discussed corrective actions that the provider needed to take. Further monitoring by Provider Services and the operations workgroup revealed that the provider did not satisfactorily address the issues.

MCP escalated the issues to our Strategy and Business Development Council (Council). MCP's Council considered all sources of information and decided to generate an RFP for lab services which ultimately resulted in the selection of a different lab partner. Throughout the process, MCP worked internally to evaluate the impact upon members, providers, operations, and financial performance and reported findings to the Executive Leadership team for review and action. MCP communicated the decision internally and provided education to providers through site visits, announcements in provider's remittance advices and on our website. Our operations team continues to monitor lab claims/encounters and reports its findings. MCP has also developed new reports to monitor possible inappropriate payments to our lab or other providers for lab services. The transition to the new laboratory partner has been well accepted by our provider network.

40.



## **Question 40 – Provider Network**

Mercy Care Plan's (MCP's) provider survey results have demonstrated our commitment to our providers by consistently and clearly communicating. We value, encourage and support provider input and feedback; including but not limited to Provider Inquiries, Complaints and Requests for Information (hereinafter referred to as PICRI). MCP has written Policies and Procedures (hereinafter referred to as P&Ps) to support and govern our process to receive, manage, coordinate and respond to provider PICRI. It is MCP's P&Ps that all employees receive adequate training/information that MCP encourages providers to submit PICRI and that we shall never retaliate (formally or informally) against a provider for submitting a PICRI. Our executive management team (Chief Executive Officer (CEO), Chief Operating Officer (COO) and Chief Medical Officer (CMO)) support the continued enhancement of our processes to encourage, receive, manage, and respond to PICRI. Given the unprecedented budget issues facing the State and AHCCCS, MCP's clear, responsive and organization-wide protocols for accepting and managing PICRI have never been more important. MCP values, encourages and supports provider input and feedback. Our established organizational, operational, managerial, and administrative systems that recognize, receive, manage, and respond to PICRI are utilized by all MCP personnel. MCP has three primary PICRI goals: 1) reinforcing open, two-way communication channels between providers and MCP, 2) assuring the accurate, complete, and timely acceptance and resolution of PICRI, and 3) managing PICRI through the tracking and trending of patterns to identify areas for improvement. Our COO is accountable and responsible for meeting these goals. The COO is supported by staff from multiple areas, including but not limited to our: 1) network development and contracting/provider services; 2) compliance; 3) fraud and abuse; 4) case management; 5) member services; 6) medical management (quality and utilization management); and 7) grievance and appeals. Our COO provides the leadership to effectively manage the PICRI process. This includes, but is not limited to, having the organizational, operational, managerial and administrative systems in place that are capable of recognizing, receiving, managing, and responding to PICRI. MCP provides initial and ongoing training of personnel from all organizational areas on the importance of PICRI, P&Ps related to PICRI, and steps the employees should take to recognize, respond or forward (to the Provider Services Representatives (PSRs) Department) and document the receipt of PICRI.

### **Reinforcing Open, Two-Way Communication**

MCP includes information, instructions and guidance for providers on who, how and when to contact MCP in our provider manual, on our website's provider portal, semi-annual provider newsletters, provider directory, and from the assigned provider service representative (PSR) during initial and on-going provider training and visits. Additional guidance and support is always available to providers if they contact their PSR or our Provider Services Department at (602) 263-3000 or (800) 624-3879, using the Express Code 631.

### **Accepting Provider Inquiries, Complaints, and Requests for Information**

We accept PICRI from providers who may access our health plan at any point within our organization. A provider may contact any MCP employee with a PICRI and trust that whenever, however and whoever receives PICRI, the provider will receive an accurate, complete, and timely response. Personnel from all our departments receive training regarding PICRI, but personnel from the following departments receive applied training on how to recognize, capture, and respond to PICRI:

- Provider services – questions and complaints regarding MCP processes, training needs, claims status, resource identification and referrals, appointment accessibility and availability including after hours, gaps in available services, and prior authorization requirements
- Member services – member eligibility verification, PCP assignments and changes, abuse and neglect concerns, complaints regarding providers, resource identification and referrals
- Medical management – medical or pharmacy authorization, disease management, utilization management, and specialist referrals
- Quality management – quality of care concerns, credentialing/re-credentialing, ambulatory record review results, EPSDT®, special program referrals, abuse or neglect of a member, and maternity care program issues
- ALTCS case management – service coordination, service interruption, providing service authorizations to providers, resource identification, and referrals
- Compliance – fraud and abuse reporting, contract requirements
- Claims inquiry/claims research (CI/CR) – claims status and payment details

### ***Capturing PICRI Information***

Regardless of when, where or who within MCP receives PICRI, our P&Ps require the employee to document the contact in our business application systems. MCP employees receive training on documenting PICRI. The call tracking modules have a pre-designed template for the employee to enter required information. This provides a uniform data base for receipt, tracking and trending of all PICRI. We use the call tracking modules as a record of telephone, face-to-face or written PICRI. MCP personnel record the following information in the call tracking modules: i) date and time of the contact; ii) provider's name, address, telephone number, e-mail address and ID number (if known); iii) description of the PICRI; iv) outcome, including date resolved and provider notification (if applicable); v) status and projected resolution timeframe (if not resolved during initial contact); vi) action plan for resolution (including details regarding if the item was forwarded to another department for research); vii) identification of actions/corrective action(s) to resolve the issue; and viii) final resolution – including date resolved and provider notification.

### **Specialized and Dedicated Provider Services Representatives (PSRs) Support PICRI**

We recognize the complexities of the ALTCS program and have staffed our Provider Services Department with PSRs who are dedicated to a specific type of Long Term Care (LTC) provider (e.g., HCBS, assisted living facilities, and nursing homes). Our PSRs receive training specific to their provider type on relevant P&Ps, claim protocols, and AHCCCS' policy manuals (ACOM/AMPM). This means each PSR is uniquely prepared to respond to PICRI from their providers. The assigned PSR works with the provider starting with the initial training and continues through scheduled visits. All of our providers have assigned PSRs to support their needs, foster communication, and support a collaborative relationship. PSRs work directly with assigned providers through telephone, our website provider portal, email, written communication, and on-site visits.

### ***Provider Services Department Roles and Responsibilities***

Under the direction of the COO, our provider services director [(PSD) (aka: Provider Services Manager)] is primarily responsible for developing, supporting, and delivering provider and internal staff training on our PICRI protocols. Our PSD coordinates with MCP's Training Department to provide the initial and ongoing training of personnel from all organizational areas on the importance of PICRI, our P&Ps and steps our personnel are required to take to recognize, respond to, forward, and document the PICRI.

The PSD is responsible for categorizing PICRI based on nature and content and updating the call tracking module. We resolve most PICRIs at the time of the contact; however, in limited instances should additional investigation be required to resolve the issue we continually advise the provider of our progress. PICRIs received after regular business hours are acknowledged the next business day, but no later than three business days following the initial contact. PSRs work each open PICRI on a daily basis and take necessary and appropriate action to resolve the PICRI.

If a PICRI is received outside of the Provider Services Department, our written P&Ps and training protocols requires the receiving employee to refer an electronic copy of the PICRI to the Provider Services Department if further action is required. The assigned PSR will follow-up with the provider to make sure we understand the purpose of the PICRI (if applicable) and if the provider agrees with the resolution. This contact may happen at the next scheduled provider visit or the PSR may contact the provider via telephone call or visit prior to that date (depending on the purpose of the PICRI).

### **Managing Provider Inquiries, Complaints, and Requests for Information**

Our PSD is responsible for: 1) accounting for each PICRI received and making sure the provider receives an accurate, complete, and timely response, 2) trending PICRI to determine a pattern, and 3) communicating trends within the organization. The PSD reviews both daily and weekly call tracking reports to identify and determine the progress of resolving outstanding PICRI, review the accuracy of closed PICRI and monitor overall performance. Our PSD uses these reports to assist PSR in closing PICRI, identifying individual provider training needs and trending issues to determine if any areas of our operations need improvement. Results of tracking and trending are used to

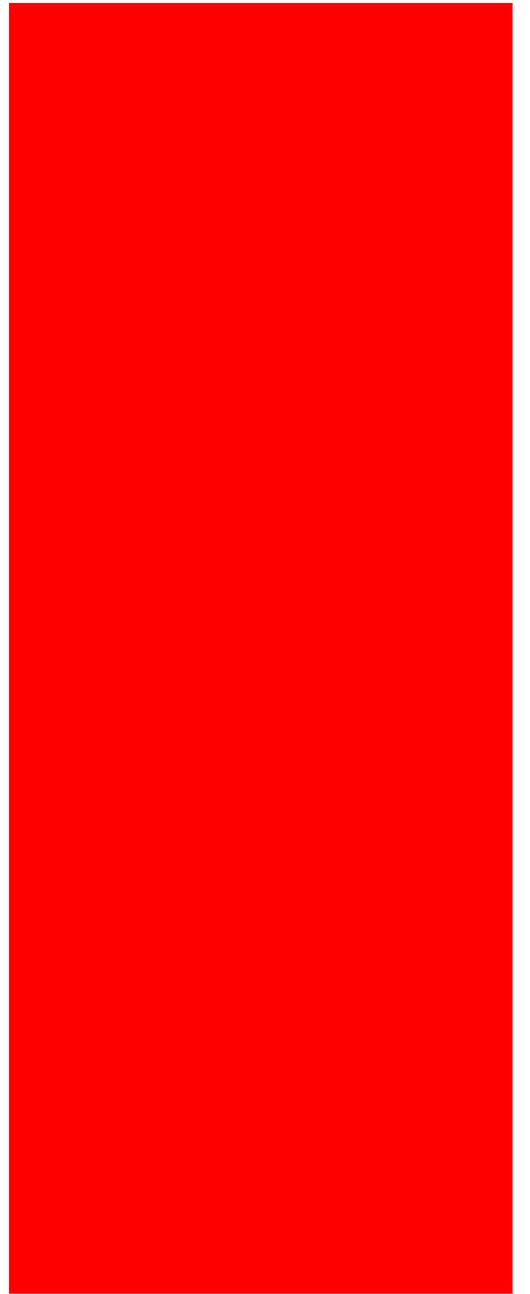
- Identify individual and systemic provider issues to determine opportunities to improve processes
- Develop and monitor performance improvement projects
- Identify and refer member service issues to our Member Services Department
- Detect and refer potential fraud and abuse to our Compliance Department
- Determine if provider training needs adjustment or enhancement
- Determine if MCP training needs to be improved



Our PSD meets with senior managers from other MCP departments including, but not limited to, member services, case management, prior authorization, and medical management (utilization or quality management) to discuss PICRI, receive input, and determine next best steps. Quarterly the PSD reports PICRI trends and identified improvement initiatives to the QM/UM Committee. The QM/UM Committee reviews PICRI trends, approves recommended intervention activities, identifies additional performance improvement activities, assigns action plans, and monitors the action plans to completion. The QM/UM Committee also utilizes these results to make recommendations regarding the quality and appropriateness of care provided to our members, provider and employee training, operational improvements, or policy changes. Quality of care tracking and trending results are reported to AHCCCS on a quarterly basis through the use of the Quarterly Quality Management Report.

Using our continuous process improvement strategy, Plan-Do-Study-Act (PDSA), the results of our tracking and trending of PICRI are analyzed to identify necessary enhancements to our processes for training personnel, or receiving or responding to PICRI. MCP has dedicated substantial resources to the PICRI process to receive, monitor and accurately, completely and timely respond to PICRI. We have seen strong evidence that this approach aids in the identification of provider's issues and concerns. As a result we have been able to avoid misunderstandings that may result in unnecessary loss of providers, disruption in care, reduced quality, and increased costs. Our robust process recognizes the importance of PICRI in improving our programs, operations, training, and provider services.

41.



### Question 41 – Provider Network

Mercy Care Plan (MCP) has a comprehensive, high-quality provider services training program. Under the direction of the Chief Operations Officer (COO), our Provider Services Director (PSD) (aka Provider Services Manager) is responsible for assuring that our Provider Services Representatives (PSRs) have the appropriate training, education, experience, and orientation to fulfill their position responsibilities and meet the needs and expectations of our provider network. Our PSD is located in Arizona and works closely with our Learning and Performance Department (L&P Department) to see that all PSRs attend and participate in all required initial, departmental-specific, and ongoing MCP trainings.

### Provider Services Training

MCP PSRs participate in 1) new hire orientation and initial training program, 2) department specific training prior to personnel having contact with providers, 3) mandatory ongoing training at a minimum of twice annually, and 4) additional training on an as needed basis. PSRs are required to participate in the following trainings and may repeat any or all as needed to facilitate understanding, interpret, and apply the tenets of our program in an accurate, complete and timely manner:

**Table 1. Provider Services Training**

Initial Training	Position Specific Training	ALTCS Specific Training
<ul style="list-style-type: none"> <li>• Introduction and Overview of:               <ul style="list-style-type: none"> <li>- AHCCCS including the effect of recent benefits changes</li> <li>- CMS including the Patient Protection and Affordable Care Act and Health Care Education and Reconciliation Act</li> <li>- ALTCS</li> <li>- AHCCCS and ALTCS Policy and Procedure Manuals</li> </ul> </li> <li>• Compliance and Fraud and Abuse (including HIPAA and False Claims Act Provisions)</li> <li>• Business Continuity and Recovery Plan (BCP)/Disaster Recovery Plan (DRP)</li> <li>• Business Conduct &amp; Integrity</li> <li>• Medicaid Complaints/Grievance System</li> <li>• Medicare Complaints/Grievance System</li> <li>• Cultural Competency/Health Literacy and Diversity</li> <li>• Quality of Care – Identification of Issues and Referral to Quality</li> </ul>	<ul style="list-style-type: none"> <li>• Duties, expectations, and code of conduct guidelines</li> <li>• Cultural competency</li> <li>• Responsive and courteous customer service</li> <li>• Provider Network Composition</li> <li>• All facets of the MCP Provider website</li> <li>• All AHCCCS programs</li> <li>• AHCCCS and MCP site visit requirements for educating providers</li> <li>• CMS guidelines</li> <li>• QNXT™ - MCP business application system               <ul style="list-style-type: none"> <li>- Proper caller verification and documentation procedures</li> <li>- Provider profile set up and changes</li> <li>- Contract validation</li> </ul> </li> <li>• Claims issues and research</li> <li>• Arizona Early Intervention Program (AzEIP)</li> <li>• Medical home</li> <li>• Geographic Service Areas (GSAs)</li> <li>• Web resources such as Map Quest, Yahoo Maps, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• ALTCS Mission &amp; Vision</li> <li>• ALTCS Guiding Principles</li> <li>• Geographic Service Areas</li> <li>• Member Eligibility</li> <li>• Member Demographics</li> <li>• MCP Department Structure</li> <li>• ALTCS Provider Manual</li> <li>• Role of the Case Manager (CM) Responsibilities</li> <li>• Case Loads</li> <li>• Specialty Areas (Home and Community Based, Assisted Living Facilities, Skilled Nursing Facilities, Behavioral Health, Medically Complex, Pediatrics)</li> <li>• Assessment Process</li> <li>• Service Engagement and Management</li> <li>• Data Entry of Information</li> <li>• Home and Community Based Services (HCBS)</li> <li>• Assisted Living Facilities (ALF)</li> <li>• Skilled Nursing Facilities (SNF)</li> <li>• Behavioral Health Services &amp; Settings</li> <li>• Cost Effectiveness Studies</li> <li>• Special Educational Projects – such as our Interdisciplinary Team that serves our most vulnerable members and programs that provide primary care in SNFs, ALFs and the home</li> </ul>

Initial Training	Position Specific Training	ALTCS Specific Training
Management <ul style="list-style-type: none"> <li>• Introduction and Overview of Integrated Care Management (ICM)</li> <li>• MCP Electronic Systems Navigation</li> <li>• Risk Management</li> </ul>		

PSRs attend orientation, initial, position-specific and ongoing training in the following phases:

- ***Phase One: Orientation and Initial Training*** – Orientation and initial training are initiated with our PSRs upon hire. This initial phase provides new employees with foundational information including, but not limited to, MCP’s organization and internal operations, CMS requirements, AHCCCS programs and Policies and Procedures (P&Ps), contract requirements, compliance and systems navigation. This phase is essential to the comprehensive development of our PSRs in understanding their roles and responsibilities.
- ***Phase Two: Provider Services Training*** – Upon successful completion of initial training and prior to having contact with providers, our PSRs are required to attend provider services specific training. During this phase, PSRs must demonstrate knowledge, retention, and understanding of the material covered in the initial training as well as the design, makeup, and functions of our provider network. This phase provides PSRs with the tools and instruction that can be applied to their positions including, but not limited to, receiving and resolving provider inquiries, complaints, and requests for information (PICRI) in an accurate, complete, and timely manner and conducting high-quality educational site visits.
- ***Phase Three: ALTCS Training*** – Following the completion of the provider services specific training, our PSRs are required to attend and participate in our ALTCS specific training. PSRs are educated about the ALTCS mission and values which promotes choice, dignity, independence, individuality, privacy and self-determination. During this phase, personnel must demonstrate knowledge, retention, and understanding of the material covered in the initial and provider services specific trainings. Our PSD coordinates with the VP of Long Term Care (Case Management Administrator/Manager) to see that our PSRs receive appropriate ALTCS training to successfully meet the needs of our providers. ALTCS specific training familiarizes our PSRs with the diverse needs of the population, roles, and responsibilities of care team members, types of available services and facilities, and challenges facing our members and providers.
- ***Phase Four: Ongoing Training*** – PSRs participate in ongoing training at a minimum of twice annually. Ongoing training is mandatory for compliance, business continuity planning, quality of care issues and service concerns, cultural competencies/health literacy, reporting member/provider complaints and AHCCCS program changes resulting in regulatory updates to our training curriculum. Additional ongoing training needs are determined by trends in business operations, the tracking, and trending of frequent questions from providers, feedback from managers, and new requirements/procedures/policies. Ongoing training is delivered using a variety of methods including, but not limited to, instructor led training sessions, online memo reviews, in-services, e-learning courses, and presentations.

PSRs are registered into orientation, initial and ongoing trainings through our learning management system. Our trainings are conducted through instructor led classroom instruction and on the job training. PSRs complete online assessments while in the classroom and are evaluated daily using a checklist of criteria constructed to identify successful knowledge transfer. The checklist is sent to the hiring manager detailing the learners’ performance at the completion of class. The trainer consults with the PSD and provides suggested additional training based upon the learners performance. Training course attendance is captured and monitored through our learning management system and reports for all courses are available on demand.

### **Monitoring of Provider Services Staff Performance**

Our providers are one of our primary resources for assuring members receive high-quality, responsive care. We are committed to furnishing our providers with the information, support, and direction they need to successfully meet the needs of our members. Our PSRs do this through telephone, on-line, written, and on-site contact. Our PSD continually monitors the performance of our PSRs by tracking and trending provider complaints, reviewing provider satisfaction surveys, and participating in departmental meetings to obtain direct feedback. Through these activities, the PSD identifies potential issues that require additional training and collaborates with the L&P Department to assure the PSRs attend

supplemental training. Should the PSR continue to have issues, our PSD is responsible for developing a performance improvement plan that includes, but is not limited to: 1) one-on-one instruction, 2) additional instructor led or online trainings, and 3) termination, if appropriate.

### **Learning and Performance Department**

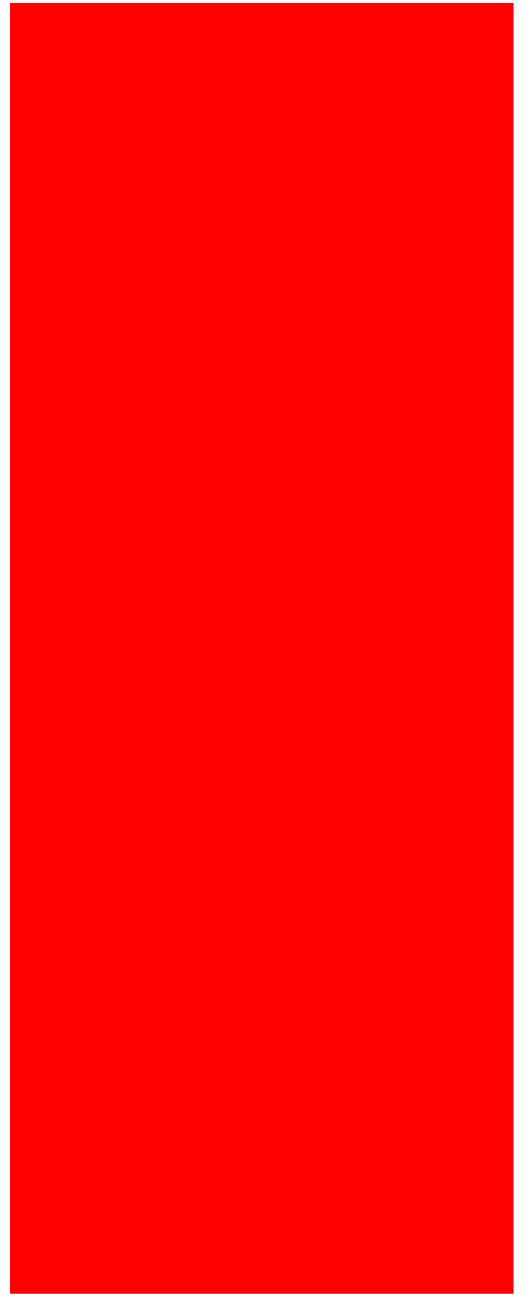
The Manager of our Medicaid Learning and Performance Department (L&P Department) assumes responsibility for the development, implementation, and management of our company-wide training program. L&P Department personnel dedicate 100 percent of their resources and time making sure that our employees receive appropriate and adequate orientation, training, and education to excel in their positions. L&P Department personnel coordinate or deliver 1) new hire orientation and initial training program to all employees, 2) department specific training prior to personnel having contact with members or providers, 3) mandatory ongoing training at a minimum of twice annually, and 4) additional training on an as needed basis. We use the following activities to deliver and track quality training throughout our organization:

- Maintaining accurate and complete attendance records
- Conducting employee needs assessments
- Developing, updating and maintaining a comprehensive training curriculum
- Developing, updating and maintaining a course catalog that is robust and readily available to all employees
- Assuring availability of L&P training personnel to answer questions and provide additional support and learning activities as needed
- Communicating operational updates and process changes to MCP employees via permanently recorded memorandums sent to affected staff

### **Training Curricula**

The L&P Department has designed user friendly, comprehensive orientation, initial and ongoing training curricula to meet the different learning styles of our employees. Our curricula are developed using the Analysis, Design, Development, Implementation, and Evaluation (ADDIE) model of instructional design and are readily available within the online resource libraries located on the MCP intranet. Curricula are maintained by the L&P Department and are updated and republished biannually using interim training memorandums. L&P Department management reviews the curricula for any needed changes or updates at least once yearly.

42.



## Question 42 – Provider Network

We understand that the needs of our provider network are dependent on the complexity of our member needs. Mercy Care Plan (MCP) ALTCS providers have both similar and different needs depending upon the members they serve and the services they provide. As a result, MCP utilizes a multidisciplinary approach to determine and evaluate the appropriate level of provider services staff necessary to meet the needs of our provider community. Our chief operations officer (COO) is responsible for assuring the design, development, and implementation of comprehensive provider services that attract, develop and support our providers to enhance performance and satisfaction.

### Understanding the Needs of the Provider Community

Under the direction of the chief operations officer (COO), our provider services director (aka: provider services manager) is responsible for assuring that provider services staffing levels continually meet the needs of our provider community. Our provider services director (PSD) is located in Arizona and works closely with other MCP leaders, managers and departmental personnel to identify, meet, and monitor the needs of our provider community. MCP departments including, but not limited to, provider services, member services, case management, and prior authorization, have direct contact with our providers and assist in identifying challenges or barriers to service provision. Department personnel work together to communicate, problem-solve, and strategize to address provider needs.

Based on our experience and knowledge, we know our providers need support and information on the following topics:

- *Member related* – eligibility, covered services, coordination of care, referrals, potential abuse and neglect, members who have excessive missed appointments, relationship deterioration between the provider and member, complex medical care, drug seeking members
- *Operations related* – provider inquiries, complaints, and requests for information (PICRI), website provider portal use, claims submission, reimbursement, medical record/documentation requirements, credentialing/re-credentialing processes
- *MCP, AHCCCS, and CMS program related* – provider manuals, changes to program standards, laws and regulations, benefits changes, subcontract requirements, compliance standards
- *ALTCS related* – the role of the Case Manager (CM), placement and service options which may include home and community based services, assisted living facilities and skilled nursing facilities, dual eligibility, community resources, behavioral health services

### Determining Provider Services Staffing Levels

Under the direction of the PSD, our dedicated ALTCS specific provider services representatives (PSRs) serve as the provider's primary-point-of-contact for PICRI regarding the ALTCS program. We determine our provider services staffing levels based on the activities required to meet our providers' needs in an accurate, complete, and timely manner. These activities include, but are not limited to, 1) responding to PICRI, 2) facilitating individual and system-wide provider trainings, 3) conducting periodic onsite visits, and 4) tracking and trending PICRI to determine patterns and opportunities for improvement.

Because the ALTCS program is complex and diverse, MCP has specially trained PSRs dedicated to meeting the many demands put on our providers. Our PSRs are assigned to providers based on their expertise and training. PSRs specialize in supporting providers including, but not limited to, primary care providers, skilled nursing facilities (SNFs), assisted living facilities (ALFs), home and community based service (HCBS) providers, and behavioral health providers. PSRs receive special training regarding the ALTCS program which includes but is not limited to: a) Mission, Vision and Guiding Principles, b) standards, c) regulations, d) policies, e) case management, and f) members and their cultural and linguistic needs.

PSRs regularly and effectively interact with network providers through office visits, telephonic discussions, email and written communications. Through these interactions, we resolve inquiries, complaints and requests for information, discuss quality of care expectations, share data and best practices, collect feedback, and provide resources. Provider services and case management staff routinely work together on site visits and individual in-service trainings. Our MCP Long Term Care Committee, comprised of key personnel from our Provider Services and Case Management Departments, meets regularly to identify network needs and program coordination when members are receiving services from two or more network providers.

## **Evaluating Provider Services Staffing Levels**

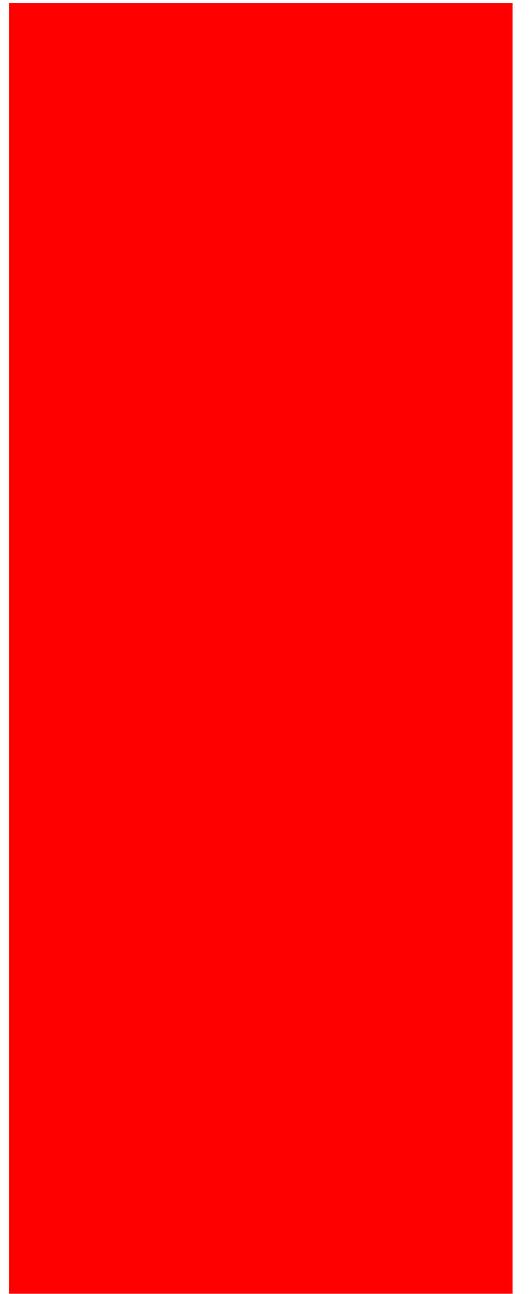
MCP adopts an ongoing “lessons learned” strategy of ongoing monitoring, adjusting, and re-adjusting our staffing levels. Our current provider services staffing levels effectively support a provider network of more than 13,000 providers. We continuously evaluate staffing levels based upon several factors including, but not limited to, the following:

- Current and projected member enrollment
- Demographics and linguistic needs of the members
- Special needs of the ALTCS populations being served
- Number of and response time for PICRI
- Results from provider satisfaction surveys
- Training needs of the provider community (e.g., individual, system-wide, hands-on, in-service, etc.)
- Frequency and duration of onsite provider visits

Our PSD regularly evaluates these factors to determine the effectiveness of our staffing levels. For example, if MCP should identify an area of sudden growth in membership of certain ethnic and/or cultural groups (e.g. Somali refugees) or within a geographic service area (such as the addition of a new GSA) MCP will expand the number of PSRs to accommodate the growth. By evaluating these factors, MCP has identified the need to add 2 additional PSRs with the ALTCS award of GSA 50.

Upon determining the need for additional provider services staff, the PSD communicates this to the COO. Our COO makes the final determination for increasing our staffing levels. Our process for assuring appropriate provider services staffing levels has resulted in a decrease in provider complaints to AHCCCS regarding MCP.

43.



### **Question 43 – Provider Network**

Mercy Care Plan (MCP) has a well-established process for identifying potential losses of Skilled Nursing Facilities (SNFs) and Assisted Living Facilities (ALFs) and implementing protocols that provide for continued service to members. Under the direction of MCP's Chief Operating Officer (COO), the Director of Network Development and Contracting is responsible for maintaining a viable provider network in the event of a contract termination or closure.

MCP complies with all AHCCCS and federal regulations regarding facility closures. We follow ACOM (section 421 – Contract Termination: Nursing Facility and Alternative Residential Setting) procedures which allow us to continue paying a facility for a member's care if they remain open and are contracted with another Program Contractor. If a facility is closing or is a nursing facility that is withdrawing from participation in the Medicaid program, MCP follows the applicable section of AHCCCS policy or federal regulations (42 CFR). When a quality of care event(s) occurs, we follow AHCCCS policy including notification to AHCCCS and external entities required by Chapter 900 of the AMPM.

### **Monitoring Network for Potential Loss**

MCP routinely monitors the network for viability and continuity, with focus on SNFs and ALFs with known or suspected viability problems or known to be at risk for closure. This monitoring serves as an early warning system and allows us to identify possible loss of a SNF/ALF, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members. The following are examples of key indicators used in our monitoring process:

- State licensure issues
- Medicare/Medicaid sanction reports
- Credentialing or re-credentialing concerns
- Failure to secure or renew required insurance
- Multiple facility requests within short time lines for advance payments to cover expenses
- Concerns raised by Case Managers (CMs), quality management (QM) staff and provider service representatives (PSRs) that suggest that facility closure may occur
- Member or provider complaints about the availability of care or services

In addition to monitoring SNFs and ALFs, we maintain communication with officials from state agencies (e.g. Arizona Department of Health Services (ADHS)) to identify potential closures.

### **Addressing Loss of SNFs/ALFs**

MCP's primary concerns during SNF/ALF losses are the safety of members and continuity of care. We take the actions listed below upon learning of potential contract termination, closure for any reason, or serious quality of care concerns:

- Facilitate a meeting with the SNF/ALF and AHCCCS to be held prior to the effective date of contract termination or any change related to contract status that could have an impact on members and/or their representatives
- Develop a communication plan that informs members and their representatives of the contract termination and the member's option to continue residing in facility until open enrollment. In a Geographic Service Area (GSA) with only one Program Contractor, we would work with the member regarding available options, which may include transferring to another facility. MCP submits the communication plan for approval by AHCCCS, provides impacted members with an explanation regarding the contract termination and informs impacted members of the steps they need to take during open enrollment
- If MCP or an outside entity such as ADHS identifies quality of care events that place the member in immediate jeopardy, MCP offers the member an alternative placement. MCP's Medical Director may also engage the member's PCP to assist in explaining the seriousness of the situation. The member or member's representative retains the right to stay at the current facility or choose an alternative placement
- Maintain a policy to disallow new admissions to a SNF/ALF when there is quality of care or contract termination issues. Our Medical Director also evaluates readmission to a SNF/ALF after admission to an acute setting to verify that the readmission is appropriate.

### **Member Transition During a SNF or ALF Loss**

MCP follows established procedures when it becomes necessary to relocate a member who resides in either a SNF or ALF from one contracted facility to another due to a closure. In these circumstances MCP coordinates a seamless transfer of the member to a SNF/ALF within the same geographic or nearby location in a safe and organized manner. The process

involves coordination and communication with internal departments, ADHS, AHCCCS, the transferring and receiving facilities, members and their families, and affected providers, as described below:

- After communication with ADHS and AHCCCS, MCP's Case Management Administrator/Manager chairs an internal meeting with management and staff from multiple MCP departments to apprise them of the situation and communicate next steps.
- The LTC Manager establishes a team consisting of the LTC Management Supervisor, the member's assigned LTC Manager, and the medical provider assigned to the facility. The LTC Manager develops a master list of all members located in the facility and their associated medical provider. The LTC Manager calls each member and/or family member to discuss the facility closure and available options which may include relocating to a new SNF, moving to an ALF setting, or returning to the community with home and community based services. The team takes the following actions:
  - Determines the order in which members will be relocated, including identifying members who may need special consideration for placement (i.e. high risk members with unstable medical conditions or significant behavioral health issues)
  - Contacts SNFs/ALFs to identify bed availability and determine how many transfers each facility can accommodate. LTC Managers consult with the Foundation for Senior Living Community Living Services staff to help identify adult foster care and ALFs that best meet the needs of specific members
  - Verifies (in coordination with ADHS) that there is monitoring of the releasing facility for staffing, food, and supplies as necessary until all of the members are moved
  - Coordinates placement including contacting family or representatives and completing authorizations
  - Provides the releasing facility with the names and contact information of MCP staff to be contacted for more information related to the member's transfer
  - Works with medical and other contracted providers to notify them of transfer and arrange for supplies, DME, pharmacy and additional PCP coverage as needed for the member's transfer orders
  - Arranges transportation to the member's new location and for transfer of copies of medical records, medications, supplies/DME, personal belongings and trust fund accounts to the receiving facility
  - Visits the facility daily, including weekends and holidays, until all members have been relocated. The LTC Manager also visits each member daily to identify and address any issues
  - Creates a final list of all members who have been moved and destinations
  - Within one week of transfer, provides a case management visit to each member and contacts the member's family to identify and assist with any issues resulting from the transfer
- The member's LTC Manager assists the member with the change of SNF/ALF. Under each circumstance, we provide translation services for members during transition to avoid misunderstanding, reduce anxiety, and facilitate quality of care

Upon completion of the transition process, MCP's Case Management Administrator/Manager conducts a follow up meeting with internal departments to verify that the transfer process has been appropriately implemented and address any questions or concerns.

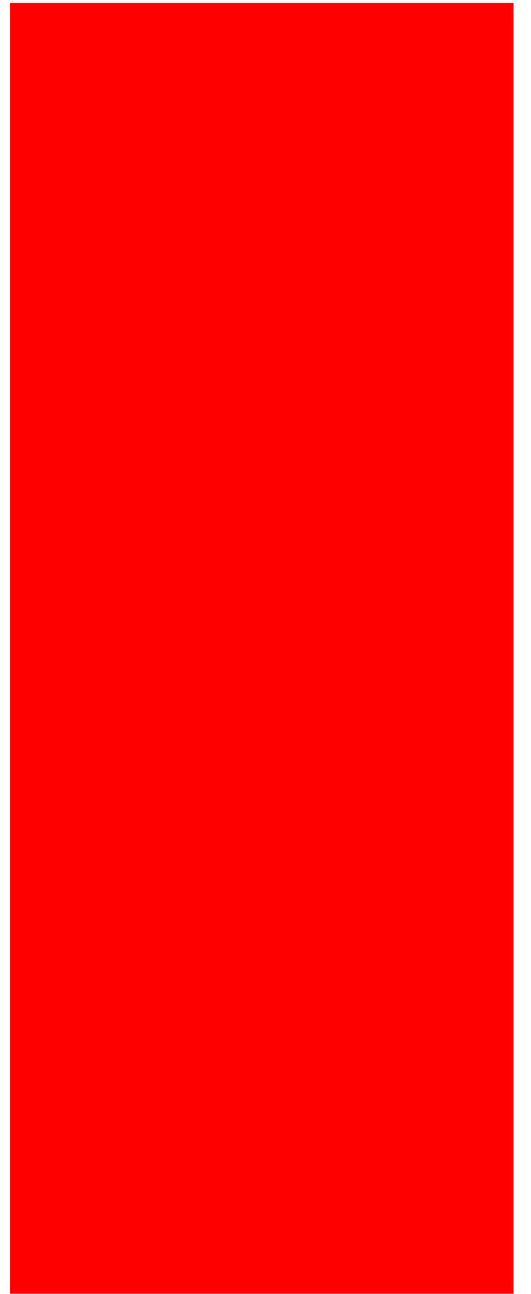
### **Case Study**

MCP was notified of an Assisted Living Center (ALC) for which DHS had completed a survey and determined that an immediate jeopardy existed due to lack of appropriate staffing, and sanitation and quality of care issues. MCP had approximately 40 residents there. After communication with ADHS and AHCCCS, MCP's Case Management Administrator/Manager initiated an internal meeting which included Compliance, Quality Management, Provider Services and Member Services to develop an action plan and immediately took the following steps:

- Case Management Administrator/Manager notified other internal departments (i.e. Current Review, Prior Authorization) to discontinue referring any new members to the facility
- LTC Management Supervisor determined the number of members in the ALC and other Program Contractors involved
- Case Management Administrator/Manager developed and submitted a communication plan to AHCCCS for approval, which informed the member or their representative of the pending contract termination and actions proposed and explained member's rights in these situations

- LTC Management Supervisor created a list of members (including levels of care) and family members to contact, as well as assigned LTC Managers and developed a plan to assist in assessment and relocation
- LTC Management Supervisor met with the LTC management team to review assignment of members to contact at the facility
- LTC Managers met with each member and/or the member's representative to discuss their options for placement and verify that they agree
- LTC Managers developed a census of all other ALC beds available in the area
- LTC Managers created a list of high risk members and determined immediate plans to relocate members (including options available to the member)
- Case Management Administrator/Manager informed AHCCCS of our intent to initiate contact of members and decision makers about the development and provide for the member's health and safety by offering relocation
- LTC Management Supervisor notified the facility our intent to relocate our members
- LTC Managers monitored the facility with daily visits
- LTC Management Supervisor and LTC Manager attended meetings coordinated by DHS to discuss their findings
- LTC Managers informed members who chose not to relocate of their rights to remain at the facility and actions they would need to take during the next open enrolment period
- LTC Managers coordinated transportation and transfer of medical records, medications, supplies/DME, personal belongings and trust fund accounts to the receiving facility
- LTC Manager determined which members required translation services to provide for a safe transfer and arranged as necessary
- LTC Management Supervisor maintained a list of members relocated to the new facility and any identified obstacles related to the move
- After completion of transition and transfers, the Case Management Administrator/Manager arranged a meeting with all internal departments that were involved to discuss the outcomes

44.



## **Question 44 – Corporate Compliance**

Mercy Care Plan (MCP) uses comprehensive and proactive strategies to evaluate and improve provider performance. All MCP departments contribute to the process of monitoring and managing providers. The Provider Services, Medical Management, Case Management, Quality Management (QM), Appeals and Compliance (including provider claims disputes), and Member Services (including member grievances) Departments compile results from monitoring activities and implement opportunities for improvement for both the individual provider and overall network. MCP has Policies and Procedures (P&Ps) in place that guide departments in monitoring performance and taking actions upon identifying provider performance issues. P&Ps address credentialing and re-credentialing, accessibility and availability of providers, provider pre-termination review, peer review, and fair hearing. Our goal is to evaluate provider performance, meet the performance measures established by AHCCCS and continually demonstrate improved outcomes from year to year.

### **Responsibility and Oversight**

While our Provider Services and Network Development and Contracting Departments (overseen by our Chief Operating Officer) maintain overall responsibility for managing the network, the Chief Medical Officer (CMO) or designee is responsible for managing the provider network related to quality of care and other clinical issues. These departments use results from our evaluation processes and input from the above departments to assess performance across various categories such as network adequacy and quality of care and services.

### **Evaluating Provider Performance**

The purpose of provider performance evaluation is to 1) establish if a provider fails to provide quality care; 2) determine if a provider follows contract provisions and relevant regulations; 3) discover provider dissatisfaction or potential viability issues before they become problematic, and 4) identify potential network gaps. MCP departments work collaboratively to establish cooperation throughout the organization in measuring provider performance. MCP uses the following methodologies to evaluate provider performance across non-medical and medical aspects on an ongoing basis:

#### ***Non-Medical Performance Indicators***

- Provider Accessibility and Availability Assessments – The Director of Provider Services (PSD) reports a summary of annual findings from accessibility and availability assessments for PCPs, maternity providers, specialists, and dental providers to the Quality Management/Utilization Management (QM/UM) Committee. The committee compares findings with member grievances to demonstrate how well the individual provider is performing. The committee also compares findings to member and provider satisfaction survey data to evaluate network-wide performance.
- Non Provision of Service (NPS) log – The Case Management Administrator/Manager submits a monthly non provision of service log to AHCCCS. The report identifies individual members who had a gap in a scheduled service, which may include attendant care, personal care, housekeeping and respite. The report shows the member service preference level, identifies the reason for the non provision of service and the provider action taken to address and meet the member preference timelines.
- Hospital Stays with Overlapping HCBS Report – A monthly report is generated to identify overlapping claim dates between inpatient and HCBS services. If the HCBS date falls on the start or end date of the hospitalization the claims are not reviewed as the member could have received services the same day of admission or discharge. If the HCBS service date falls within the admission or discharge date, those services are flagged and the PSR completes an investigation and recommends a resolution.
- Member Grievances and Provider Complaints/Claim Disputes – Member Services, Provider Services, Appeals/Grievances, Case Management, QM and the Compliance Departments work together on MCP cross-functional workgroups dedicated to reviewing member grievances and provider complaints/claims disputes. These workgroups track and trend member grievances and provider complaints/claims disputes on a quarterly basis to identify patterns and report findings to the QM/UM Committee. In conjunction with reviews of panel size/status, the committee identifies providers who exceed complaint thresholds for appointment availability.
- Member and Provider Satisfaction Surveys – MCP conducts annual member and provider satisfaction surveys to assess areas that are working well network-wide and identify opportunities for improvement. The QM/UM Committee reviews the results and develops recommendations for service improvement opportunities.
- Medical Performance Indicators Quality of Care and Service Complaints – MCP identifies Quality of Care (QOC) concerns and service complaints from both internal MCP staff and external referral sources (e.g., members, providers, state agencies). We identify many QOC concerns through calls received from members, their families, or their responsible party in our Member Services call center or from the member's LTC Manager. MCP requires our staff to

refer all service complaints to the Member Services Department for tracking, trending and resolution. Any received or perceived quality, risk management, abuse and neglect or safety issues are referred to the QM Department using our standard quality/risk management indicator form. As mentioned above, MCP developed a workgroup dedicated to addressing escalated member-initiated concerns regarding providers. MCP communicates QOC concerns internally through this process and reports trends to our QM/UM Committee.

- **Chart Audits** – The purpose of chart audits is to evaluate documentation of medical information in the records of PCPs, OB/GYNs, and other specialists in the MCP provider network. Audits include review of adult and child preventive elements as well as coordination of care with behavioral health providers. Our QM Department conducts audits and reports on findings to the QM/UM Committee. **Audits of Home and Community-Based (HCBS) Providers**– MCP’s QM Department conducts annual onsite clinical audits of HCBS providers, including behavioral health clinics, servicing LTC members using an audit tool to review member records. The QM Department summarizes audit results and presents information to the QM/UM Committee. The QM Department’s specific quality monitoring program includes particular elements that are embedded in the standardized monitoring tool. These elements are designed to assess attendant care, personal care, homemaker, and respite care. Specific factors for each service are audited. For instance, in monitoring attendant care we review and verify: 1) an applicant interview within 14 days of contacting the contractor; 2) a written agreement, signed by the member, which delineates the worker’s responsibilities; 3) records of on-site supervisory visits; 4) records of training and evaluation of all care-givers, including immediate family members as paid attendant caregivers; and 5) records of specialized training for attendant caregivers to provide necessary services to members (e.g., Alzheimer’s or cognitive disabilities).

In monitoring personal care we review and verify: 1) documentation of direct supervision of personal care provider’s rendered services until the personal care provider is determined competent in each necessary skill; 2) the member’s individualized care plan to confirm inclusion of duties and tasks necessary for maintaining the member’s self-sufficiency (e.g., bathing, dressing, transferring, grooming, toileting, and feeding); and 3) documentation demonstrating evidence of timely and complete supervisory visits.

In monitoring homemaker services we review and verify: 1) documentation of completed individualized care plan tasks, including: a) laundry; b) cleaning to maintain a safe and sanitary living environment; c) meal planning, shopping, and preparation to meet the member’s nutritional needs; e) other duties and tasks as described in the individualized care plan; and 2) documentation demonstrating evidence of timely and complete supervisory visits.

In monitoring respite care services we review and verify: 1) records of training and evaluation of paid respite caregivers; 2) documentation of adherence to the individualized care plan; and 3) records of on-site supervisory visit.

MCP’s comprehensive monitoring program for members’ in-home services is based on reviewing and verifying documentation for attendant care, personal care, homemaker, and respite care for each contracted service provider. MCP annually audits these contracted service providers and selects a sample of member records from each provider to complete the monitoring process.

## **Disciplinary Actions**

Through the systematic collection and analysis of data on provider performance, MCP is able to evaluate and identify opportunities for improvement and determine the best intervention strategies for improving performance. For issues that are attributed to a particular provider, the provider’s issue or concern is brought before one of MCP’s cross-functional committees or work groups where it can be researched and resolved by those who are closest to the situation. Follow up actions may involve provider education, corrective action, and verification of sustained improvements in performance. MCP takes further action in instances where provider performance does not improve or if there are significant QOC concerns. MCP’s actions differ depending on whether concerns are non-clinical or clinical in nature.

### ***Non-Clinical Issues***

The PSD reviews results from provider accessibility and availability audits and member grievances and directs PSRs to follow up with providers who are non-compliant with accessibility and availability standards. Follow up may include additional onsite visits or outreach telephone calls to re-educate the provider on compliance requirements. The PSR continues to monitor provider compliance each month for up to three consecutive months thereafter. PSRs may also ask providers to sign an attestation to attest that they comply with accessibility and availability standards or risk panel restrictions.

Should the problem continue, MCP sends a letter to the provider that explains the issue and requests a Corrective Action Plan (CAP). The provider must submit the CAP within 15 business days and the CAP must be approved by MCP. The

PSR sends a follow up letter to the provider reminding them of the CAP due date and content. Upon receipt and approval of the CAP by MCP, the PSR monitors the provider's performance until the CAP is successfully completed. If the provider does not improve performance, the MCP Medical Director or Chief Medical Officer contacts the provider by letter, telephone call or site visit to discuss non-compliance and offer assistance. MCP may recommend further corrective action, panel or referral restrictions or possible termination from the network if unacceptable performance continues.

When termination is recommended, MCP follows provider pre-termination procedures which include review of the potential termination by multiple internal departments. Under this process, the department requesting the termination completes MCP's provider pre-termination form and routes it to MCP departments (Network Development and Contracting, Provider Services, Member Services, Finance, Health Plan Operations, Appeals, Compliance, LTC and Medical Management) to assess implications of the termination and verify that the termination is implemented appropriately. The requesting department then presents findings at MCP's Strategy and Business Development Council (Council) for a determination regarding whether to proceed with the termination. The Council includes executive management and vice presidents from all MCP departments and determines business strategy for the organization (including the provider network). The Compliance Department reviews terminations recommended by the Council and sends notification to AHCCCS as appropriate. Upon AHCCCS approval, MCP implements the termination by notifying MCP departments, the provider and affected members; arranging for transition of care; and updating our claims/provider data management systems to reflect the termination.

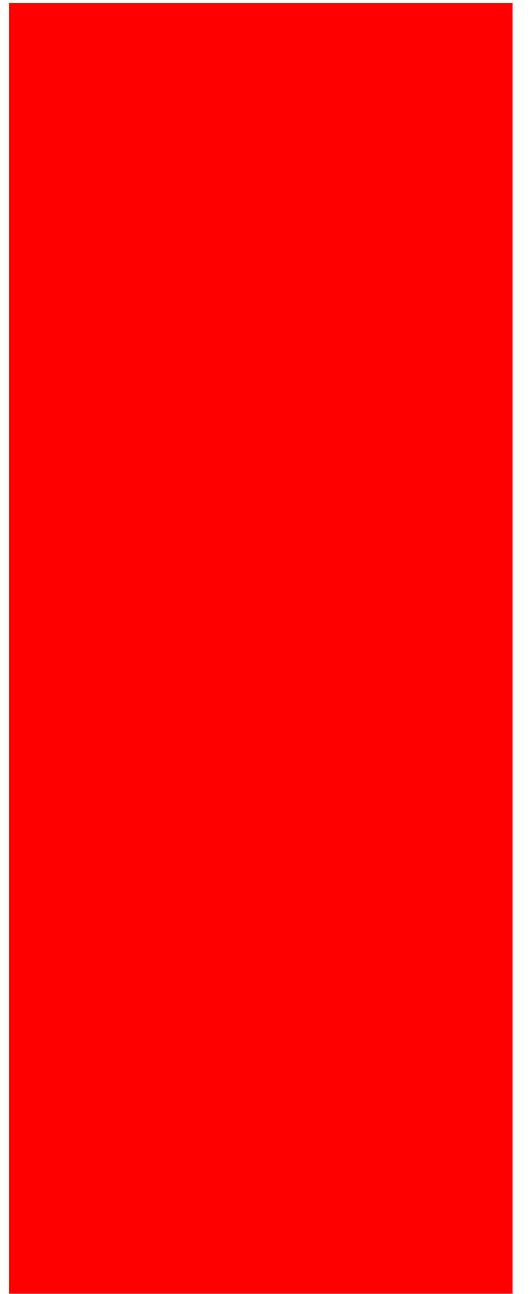
### ***Clinical Issues***

Our QM Department investigates QOC issues referred by external or internal sources. MCP requires employees who identify a potential quality, risk management or safety issue to refer the issue to the QM Department for investigation, resolution, and follow up. A Medical Director receives escalated cases from either source, reviews the referral data, then takes immediate action to resolve the issue or works with the provider to request further information. After review of the additional information, depending on the severity, the Medical Director may make recommendations to the provider, and track implementation of those recommendations or present the case to the Peer Review Executive session of the QM/UM Committee for review, and recommendation. The CMO makes the final decision based upon committee recommendations which may include peer-to-peer contact by the CMO with the provider, development of a corrective action plan, provider education, restricting member assignment or referrals, or terminating the provider's contract. The CMO and QM/UM Committee both approve any corrective action plans that the provider submits and monitor the action plan through to completion.

Based on findings of the review or investigation of a QOC concern, MCP reports information to AHCCCS or the appropriate regulatory board or agency as appropriate. The CMO notifies MCP's Board of Directors of the decision and the affected provider of the proposed action. MCP providers have the right to appeal the determinations and/or actions made by MCP through our provider appeals process identified in our provider manual. This includes the provider's right to request a Fair Hearing if they disagree with determinations related to their credentials.

In addition to the peer review process, MCP also utilizes our re-credentialing process to determine whether a provider will continue participation in the MCP network. Our Credentialing Committee is an interdisciplinary committee that includes cross-departmental representation along with network providers. This committee is responsible for reviewing provider qualifications, including any previous provider issues and making a recommendation regarding re-credentialing of the provider. The Credentialing Committee forwards its recommendation to the CMO who is responsible for the final determination regarding continuation of the provider's credentials. The CMO presents summary information to the QM/UM Committee and Board of Directors. Providers have the right to request a Fair Hearing should they disagree with the recommendation of MCP's Credentialing Committee.

45.



## **Question 45 - Network Summary**

Mercy Care Plan (MCP) has a long and proven history serving members in Arizona. Established in 1985, we offer services to AHCCCS acute, Long Term Care (LTC), Health Care Group, and Developmentally Disabled members throughout various counties. In addition, our Medicare Special Needs Plan serves dual eligible members state-wide. We have served ALTCS members since 2000 and are proposing to expand ALTCS services to the Pima and Santa Cruz GSA, where we currently provide the full range of AHCCCS covered services to almost 30,000 members in Pima County.

MCP successfully uses a comprehensive approach to validate that our network maintains the ability to provide all covered services to ALTCS members. Our network is diverse and responsive to member needs, providing member choice across acute, institutional, home and community based, and alternative residential settings while allowing members to receive services in the least restrictive setting. To accommodate the membership and expected utilization of Pima and Santa Cruz GSA members, we have pursued contracts with providers who currently serve the existing membership in this GSA as well as additional providers across provider types. Our goal is to provide for a seamless transition of members from the current incumbent to MCP, preserving continuity of care and avoiding member transition to new providers. MCP provides ongoing support for our providers through our Provider Services program, which includes Provider Services Representatives (PSRs) who are dedicated to the ALTCS program. Our ALTCS PSRs receive specific training regarding the ALTCS program, standards, regulations, policies, case management and other covered services, members and their cultural and linguistic needs. We will apply this same program to new providers in the Pima and Santa Cruz GSA.

### **Numbers and Types of Providers**

MCP's ALTCS network in Maricopa County has historically met or exceeded AHCCCS and federal requirements regarding numbers and types of providers across services and counties with minimal deficiencies. Deficiencies are reported in our Network Development and Management Plan, attached in response to Question 36. The network is supported by written agreements that obligate providers to comply with AHCCCS and federal requirements including those for after-hours and appointment availability. Under the direction of the Chief Operating Officer (CMO), MCP's Directors of Network Development and Contracting, and Provider Services facilitate network monitoring and management activities, coordinating with other internal departments that participate in the process. Key aspects of monitoring our network to verify the appropriate numbers and types of providers include:

#### ***Credentialing Process***

MCP's credentialing process verifies that providers have the appropriate training, experience, specialization, and adequate hours of operation to serve the ALTCS membership. Providers must complete our credentialing process before they may serve members. (Our process provides for use of provisional/expedited credentialing if situations arise where we must expedite credentialing to best meet the needs of our members.) As part of the process, we conduct site visits to verify that a provider's office location provides physical access for members with disabilities. We also capture information regarding the languages spoken and cultural backgrounds of providers, and verify that network providers offer services that reflect the diverse needs of our members.

#### ***Geographic Location of Providers***

We conduct regular GeoAccess reports to validate that our network offers a sufficient number and specialization of providers by county and GSA within required travel distance standards (including acute care, behavioral health, HCBS, institutional and alternative residential settings). Results confirm MCP's capacity to serve members within the standards in the Maricopa, Pima, and Santa Cruz GSAs. In developing GeoAccess data for the Pima and Santa Cruz GSA, we assumed we will serve 100% of the current eligible members. MCP has minimal deficiencies which we address in detail in our Network Development and Management Plan (attached in response to question 36). We note network gaps in the Network Attestation Statement, which has been signed and included in our proposal. In accordance with the ACOM Network Summary Policy we also submit information about each provider in our network for AHCCCS to further verify network adequacy and compliance with standards. The network summary listing of the provider network is uploaded and is available via the AHCCCS FTP site.

#### ***Appointment Availability/After Hours Access Surveys***

MCP PSRs provide ongoing education to network providers regarding appointment availability and after-hours access requirements. We conduct annual surveys for primary care, specialist, dental and maternity care appointments to verify compliance. Overall, 99% of our PCPs, specialists, and dentists combined; and 96% of our OB/GYNs meet appointment availability standards in all GSA's. For appointment waiting times, 97% of our providers comply with AHCCCS standards.

### ***Grievance Data***

In addition to GeoAccess reporting, we review member grievances on a real-time basis to identify if members are experiencing difficulty obtaining covered services or finding an available provider. Management staff from Member Services, Case Management, Provider Relations, and Quality Management meets weekly to address and resolve escalated member-initiated concerns regarding providers including issues involving access to care. Upon identifying access to care concerns, Provider Services follows up with providers to address provider-specific concerns and reports feedback at weekly meetings. In addition to real-time targeted follow up, MCP produces a monthly grievance report that identifies the type of grievance, allowing MCP to identify trends regarding access to care and take action. We supplement review of grievance data with annual member and provider satisfaction surveys. Satisfaction survey data also show a high percent of satisfaction with MCP regarding access and availability of care.

### **Collaborative Arrangements with Providers**

To further support the specialized needs of ALTCS members, MCP has developed innovative arrangements with providers and community agencies. Described below, these relationships support the goals of providing accessibility to care; reducing avoidable ED visits, inpatient admissions, and re-admissions; allowing members to remain in their residential locations; collaborating with stakeholders; and improving outcomes while saving costs:

- We contract with PCPs that offer house calls to members in their homes or residential settings during the day, evenings, and weekends. We have agreements with PCPs so that this service will be available in the Maricopa, Pima, and Santa Cruz GSAs.
- In the Maricopa, Pima, and Santa Cruz Counties we developed an urgent care arrangement that offers specialized, focused urgent care facilities to improve access to after hours care.
- In light of our strong commitment to patient centered medical homes, MCP launched patient centered medical homes for our ALTCS members with St. Joseph's Family Practice Clinic in Maricopa – patient centered medical homes are an exciting and promising approach for providing highly coordinated and responsive care to ALTCS members. MCP has identified ten additional practices in Maricopa and Pima Counties for implementation as patient centered medical homes that we will implement during CY 2011.
- In collaboration with the Carondelet Medical Group and the University of Arizona in Pima County, we will launch a diabetes management program in CY 2011 that focuses on improving diabetes care using integrated interventions including diabetes educators, nutritionists, diabetes day clinics, and telemonitoring for at risk members.
- Expansion of our behavioral health network and programs in Maricopa, Pima, and Santa Cruz Counties through collaboration with Community Partnership of Southern Arizona (CPSA). As a result of this agreement we are further expanding our behavioral health expertise and broadening services to enhance our excellent behavioral health network for ALTCS members. CPSA's Consultation and Clinical Intervention Team is an innovative approach for assessing members at high risk for placement disruption and designs services to meet members' needs. As the Regional Behavioral Health Authority in the Pima Region for the past 16 years, CPSA has a comprehensive service network and relationships with a vast array of providers. CPSA will facilitate access to a full continuum of behavioral health services available to members in Pima County upon contract award.
- Improving services to homeless members in Pima County through the Southern Arizona Health Village for the Homeless Van of Hope community collaboration. This program provides mobile medical services at sites frequented by homeless members.
- We have long-standing agreements with Federally Qualified Health Centers (FQHCs) in the Maricopa GSA, including Adelante HealthCare, Maricopa Integrated Health System, Mountain Park Health Center, and Wesley Community Center. We also have effective agreements with FQHCs in the Pima and Santa Cruz GSA, including El Rio Health Center, Marana Health Center, Mariposa Community Health Center, Desert Senita Community Health Center and United Community Health Center.

### **Network Gaps and Follow Up**

MCP's objective is to anticipate and avoid potential network gaps. The above information helps us verify that the network is sufficient to provide all covered services and proactively take measures to avoid future disruptions. Proactive measures may include provider education initiatives, recruitment within specific geographic service areas or across certain services, and innovative arrangements with providers and community organizations. However, if a gap does occur, we take immediate steps to address the gap so that our members' care is not compromised.



MCP also implements follow up education and corrective action with specific providers when they fail to adhere to requirements. For example, providers who fail to meet appointment availability standards or who have unresolved/repeated member complaints receive follow up education and may be placed on corrective action. We monitor them on an ongoing basis until they achieve and sustain performance improvement. We also formally review data and trends at interdisciplinary committee meetings, where staff from various MCP departments reviews data from network monitoring tools and makes recommendations to improve the network.